

DIFFICULT DECISIONS: KARIMOJONG HEALING IN CONFLICT

By

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Abstract

This dissertation examines Karimojong ethnomedicine, focusing on maternal therapeutic decision-making and the healing work of indigenous practitioners. Political and environmental instability, coupled with inequality and an institutional emphasis on biomedicine, has resulted in long-term suffering among the Karimojong of northeast Uganda. This area provides few socioeconomic opportunities beyond agropastoralism, and most Karimojong families live entrenched in poverty and violence; thus, families go without basic necessities and have normalized their continued state of ill health as a coping method to deal with relatively high levels of child illnesses and death.

Over a period of 10 months of ethnographic fieldwork, I heard, witnessed, and experienced Karimojong communities “making do” in the face of abject structural violence. The social, political, and economic marginalization of Karamoja has shaped the distribution of healthcare resources and local experiences of health and illness. The Ugandan Ministry of Health actively promotes biomedicine as the preferred healing method and regards Karimojong indigenous therapeutic strategies as ineffective, harmful, and outdated. While local healing practitioners have incorporated various biomedical insights, the Western-based health sector has not welcomed Karimojong healing as a viable therapeutic strategy.

The Karimojong are medically pluralistic and rely on both biomedicine and indigenous medicine. Karimojong healers treat illness, bless pending cattle raids, and maintain the spiritual health of communities. The healers’ work underscores

their importance to community well-being and as advocates of holistic healthcare. For child illnesses, Karimojong mothers chose healthcare methods pragmatically and utilized multiple strategies including herbal remedies, consultations with healers, pharmaceuticals, and frequenting biomedical clinics. Informants described the reasons biomedicine could not wholly replace their indigenous healing systems and the constraints placed on therapeutic decision-making.

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List of Acronyms

AVSI	The Association of Volunteers in International Service
BCMS	Bible Church Mission Society
CBHC	Community-Based Healthcare
CFE	Canine Follicle Extraction
CHC	Church Health Commission
CMA	Critical Medical Anthropology
CUAMM	<i>Collegio Universitario Aspiranti Medici Missionari</i> (University College for Aspiring Missionary Doctors)
CVM	Christian Veterinary Mission
FBO	Faith-Based Organization
GoU	Government of Uganda
HC	Health Centre
HRW	Human Rights Watch
IIACM	International Institute of Alternative and Complementary Medicine
IMAU	Islamic Medical Association of Uganda
IMF	International Monetary Fund
ItalCoop	Italian Cooperation
JMS	Joint Medical Store
KACHEP	Karamoja Christian Ethnoveterinary Program
KATHES	Karamoja Traditional Healers and Health Systems Project
KAR	King's African Rifles
KCS	Karamoja Cattle Scheme
LC	Local Council
MAKOHA	MAKO Herbal Association
MoH	Ministry of Health
MSF	<i>Medicines Sans Frontier</i> (Doctors Without Borders)
NGO	Nongovernmental Organization
NRM	National Resistance Movement
PEMA	Political Economy in Medical Anthropology
PPHP	Public-Private Health Partnership
PROMETRA	The Association for the Promotion of Traditional Medicine
SAP	Structural Adjustment Program
TB	Tuberculosis
TBA	Traditional Birth Attendant
THETA	Traditional and Modern Health Practitioners Together against AIDS and other diseases
UCMB	Uganda Catholic Medical Bureau
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UPMB	Uganda Protestant Medical Bureau
UMMB	Uganda Muslim Medical Bureau

UPDF	Uganda's Peoples Defence Force
WFP	World Food Program
WHO	World Health Organization

Chapter 1 Introduction

Six years ago I gave birth to this boy, Longok, in my hut. The five days we stayed inside the hut, he was well, but after the fifth day he developed diarrhea. I tried to take him straight away to St. Kizito hospital. He's my first child and I didn't know what to do. I carried him to the trading center, which took me nearly five hours. Along the way someone told me it was Sunday and that the hospital's out-patient clinic was closed. I decided then to take him to an amuron [healer] at a village on the edge of the trading center. This amuron gave me an herb with red roots that cost me 1,000 shillings. We stayed with a relative near the trading center. At night I prepared the herb for Longok – I crushed the roots, soaked the powder in water, and gave a tiny bit to the baby to drink. The next morning I immediately took him to the hospital's out-patient clinic. The nurse decided to admit him to the ward, where he was put on a drip. Longok stayed on the drip for two days, and was then given oral rehydration salts for another full day before he was discharged. St. Kizito charged me 1,500 shillings for the help.

Longok stayed some months without getting sick again. Then he got lokore [pneumonia]; he was breathing very fast and the old women in my homestead told me it was lokore. They said this sickness can only be treated by Karimojong medicine so I took him to another amuron. This healer removed evil eye and gave Longok a special herb to drink. The healer gave me the herb to take home and I continued giving the medicine to him for several days. The amuron lives in a village nearby and allowed me to pay her with three kilograms of sorghum and beer. I chose this amuron because none of the healers in my homestead know how to treat lokore.

This boy came close to death many times and I struggled so much to keep him alive. His treatment has been costly and I was young and did not know what to do. When Longok was able to sit upright by himself he started urinating blood and at times there was pus. I took him back to St. Kizito hospital where he was again admitted. He had constant fever and diarrhea, in addition to the blood and pus. The diarrhea and fever continued. He stayed for two months and even received tuberculosis treatment. The whole treatment cost 1,500 shillings, but I also had to pay for our upkeep and food. Finally, the nurse told me to take Longok home. He was still sickly though and we lacked many things needed to make him better. I have not been married with cattle and my husband does not really provide for us here. Even now I have to sell charcoal in Matany trading center just to buy some small food stuff for the children. When Longok was sick we struggled just like now.

Once Longok came home I asked women here for help to make Longok stronger because his diarrhea and fever would not stop. One woman told me about a renowned herbalist who lived in Matheniko County. Because my aunt was married to a Matheniko man and lived there, I decided to go visit her. My aunt took me to the amuron who removed evil eye from Longok and gave him an herb to drink. The following day I went back to that healer and had Longok's false teeth removed. I did not pay this amuron because she is the sister-in-law of my aunt.

Although his false teeth were gone and the diarrhea lessened, Longok became very sick. It was so bad that we had to stay in Matheniko for three days and then I just risked our lives [via attacks by armed warriors] and returned back home to Bokora County with Longok by foot. We slept one night at home and then the following day made the journey back to the hospital. The nurse put Longok on drip right away. Luckily because Longok had just been admitted for the bloody urine, the nurse did not look in his mouth. If she had seen his wounds from the false teeth, I could have been slapped. This time, Longok was on drip for one week, which cost me another 1500 shillings. The drip was put in his forehead because he was so dehydrated, but this made his face swell, and the nurse had to move it to his temple. He was at St. Kizito's for one week and then he became okay.

His fourth stay at the hospital came when he was able to stand. Longok had a bad fever which no herbs could cure even though I tried many. So, I took him to the drug dispensary where he was given three injections – one a day. On the fourth day people at the dispensary told me to go immediately to the hospital. It was there that he was admitted again. Since then it has just been hunger that has bothered him. His hunger makes it so he is never well (AP92 5/7/07).

This is a story of a Karimojong mother struggling to keep her child alive in the most desperate of situations and typifies the difficult conditions from which Karimojong suffer daily. During interviews Karimojong women graciously narrated stories, like the one above, and explained how they attempted to treat child illnesses in an area known for its stark living conditions. Karimojong stories relayed information about their therapeutic decision-making processes, the medical

treatments that are available and how they utilized them, and how structural violence has shaped these processes and treatments.

This dissertation examines local healing among Karimojong people in northeast Uganda (Figure 1.1) from an anthropological perspective. Specifically, this work uses the example of Karimojong health and healing to illuminate how externally imposed, top-down development models fail to address the needs of the local population.



Figure 1.1 Map of Uganda

I examine the structural complications in the political economy of Karamoja, which give rise to opportunistic responses by the Karimojong to increase their chances of survival. Karimojong informants described how they relied on both biomedicine and indigenous healing technologies and pragmatically chose among a range of

therapeutic strategies depending on the context of the illness bout and other external factors (such as monetary resources). I also examine the role of Karimojong healing practitioners and the diffusion of biomedicine into Karimojong healing methods.

The Karimojong are one of several Nilotic-speaking groups living in the Karamoja region in northeast Uganda (Dyson-Hudson 1966, Knighton 2005, Mkutu 2007). The Karimojong were historically transhumant pastoralists who kept mixed livestock herds, which they grazed over vast areas of land, and cultivated crops at semi-permanent agricultural homesteads (Gray, Leslie, and Akol 2002, Knutsson 1985). Rainfall in Karamoja is scarce; multiyear droughts and short-term flooding severely limit the agricultural potential in this region and contribute to periodic famine. Maintaining diverse livestock herds, therefore, is essential for survival and accounts for the high social and economic value the Karimojong place on cattle (Dyson-Hudson 1966).

In addition to its unpredictable rainfall and limited agricultural potential, armed violence in the form of livestock raids, vehicle ambushes, urban thuggery, and, as of this writing, a disarmament campaign known for its human rights abuses is prevalent throughout the region (HRW 2007, Stites, Mazurana, and Akabwai 2007, Sundal 2007). Escalating violence has left many Karimojong villages without cattle and few alternatives for survival (Gray, Akol, and Sundal 2007, Gray et al. 2003, Sundal 2006).

The process by which ill health is embodied, acknowledged, diagnosed, and treated highlights not only cultural notions surrounding sickness and health, but

also underscores the complex interaction between socioeconomic constraints, medico-religious beliefs, and political pressures placed upon a population. The examination of therapeutic decision-making or health-seeking behavior, at both the individual and group level, emphasizes the process of illness recognition, the quest for therapy, and the selection and administration of treatment choices. Karimojong health-seeking behaviors pragmatically combine indigenous remedies and Western-based biomedical approaches. Political and environmental instability and an institutionalized emphasis on Western medicine, however, have inhibited this integrative healing strategy. Because the Karimojong experience high child morbidity and mortality, child deaths are normalized as being a part of the Karimojong experience. Thus, it was not unusual for Karimojong mothers to report their loss of children who had succumbed to “curable” sicknesses, such as diarrhea, malnutrition, and malaria.

Research Objectives

This dissertation provides an analysis of the changing Karimojong medical system as a consequence of long-standing armed conflict, environmental degradation, and Western intervention and examines the cultural context of Karimojong indigenous healing and child health. My research objectives are:

- To describe Karimojong ethnomedicine in its current social, political, and economic contexts.
- To examine maternal therapeutic decision-making in regard to child illnesses.

- To chronicle the training, cultural roles, and medical expertise of Karimojong healers.
- To examine the interactions among medical systems available to the Karimojong, with a specific focus on how biomedicine has influenced Karimojong indigenous medicine.
- To account for the effects of structural violence on Karimojong well-being and available healing methods.

Dissertation Overview

In Chapter 2, I situate the Karimojong as part of the Eastern Nilotic language family of pastoralist populations in Sudan, Kenya, and Uganda. Chapter 2 first reviews the impact of colonial and postcolonial administrative policies on the territorial homelands of the Karimojong and neighboring pastoralists. It then moves from a review of the history of Karamoja to the population that is the focus of this dissertation—the Karimojong who live in Moroto District, Uganda. I describe the political ecology of Moroto District and its impact on Karimojong lifeways. Finally, I examine the effects of armed violence in Moroto and show how the recent inundation of automatic weapons has altered both inter-ethnic conflict as well as governmental responses to it.

Chapter 3 summarizes the theoretical orientation of the study. Medical anthropology offers numerous perspectives from which to study health and healing. The shifts in theoretical perspectives correspond to the changes experienced in the discipline of anthropology as a whole; similarly methods and theories to understand

culture, health, and illness have changed within medical anthropology. An interpretative approach offers insight into emic explanations of therapeutic decision-making. Complementing this, a critical perspective examines the broader political and economic forces that shape and enforce local experiences of health and illness and corresponding healthcare resources. Phenomenology and critical medical anthropology illuminate how Karimojong perceive illness and well-being and enabled me to address the effects of armed violence, famine, and sociopolitical marginalization on Karimojong health and healing.

Chapter 4 describes the research design. For the first four months of the dissertation fieldwork I stayed in Uganda's capital, Kampala, where I took formal NgaKarimojong language courses. Using ethnographic field methods, I interviewed mothers and healers on Karimojong ethnomedicine. These interviews provided data – often through illness narratives – on how communities manage ill health, why mothers utilize particular treatment methods, and how local healing methods are incorporated into the biomedical healthcare system. I analyzed the qualitative and quantitative data using a two-phased coding system with the aid of ATLAS.ti, a text analysis software program.

In chapter 5, I discuss how biomedicine became the dominant form of healthcare promoted by the Ugandan Ministry of Health (MoH). This chapter examines how Uganda moved from being one of the leading African states in biomedical healthcare services to its current poor state due to the Ugandan Civil War, decentralization, and structural adjustment policies. The MoH classifies

biomedical health facilities according to the number of staff, medical services provided, and level of patient care. In addition, each subcounty in Uganda has one biomedical facility assigned to serve its designated residents. These units range from drug dispensaries in some locales to hospitals in others and can be either state funded through the Ugandan government or operated and financed by faith-based organizations (FBOs). Thus, quality of care, availability of services, and the mission of the health centers varies greatly. Chapter 5 also identifies the biomedical health facilities in Moroto District and examines the health records from two subcounty facilities – a drug dispensary and a level-three health center that offers in-patient and out-patient care. Karimojong informants explained how biomedicine failed to address their needs: they suffered harsh punishment for using indigenous remedies; biomedicine is relatively expensive; and the health clinics are located far from their communities, which require long and precarious travel. I also address the dichotomy between biomedicine and Karimojong ethnomedicine that has resulted in two parallel therapeutic channels: the state’s exclusively biomedical system, which prohibits local healing techniques; and the underground health system, which relies on the covert use of indigenous healing techniques.

Chapter 6 expounds on three core features of Nilotic healing: the connection between indigenous healing and the cosmos; the classification of illnesses; and the process in which afflicted individuals become practicing indigenous healers. Karimojong indigenous medicine and its healing practitioners are not static representations of traditional healthcare systems, but have adapted over time in

response to globalizing pressures, such as biomedicine and Christianity. Using data from interviews with healers, I describe the Karimojong cosmos and the links between the spiritual world and its influence on human health. I provide examples of Karimojong illnesses that are wholly of the spiritual realm and, as such, cannot be treated with biomedicine. Chapter 6 provides an ethnographic example of a Karimojong girl undergoing the “the call to healing” to chronicle the transformative journey of the chosen from an afflicted state to that of a practicing healer. Chosen Karimojong follow a similar call to healing: first they become ill or behave in an uncharacteristic manner; they then seek advice from Karimojong healers who recognize their illness as a call to healing; finally, they are initiated as a practicing healer and return to a healthy state. The chapter concludes with a description of *Akitmuroiyar*, a healer initiation ceremony.

In Chapter 7 I describe varied aspects of Karimojong indigenous medicine. Local healing among the Karimojong maintains and promotes individual and community health through an integrated set of strategies that reflect their cosmology and their economic, political, and cultural histories. Indigenous responses to potential threats and misfortunes include healing bodily afflictions, addressing past wrong doings, and restoring social order through consultation with local specialists, using herbal therapies or over-the-counter pharmaceuticals, and utilizing biomedical facilities. First, I discuss the implications of Uganda’s definition of and policies in relation to indigenous medicine, the nongovernmental organizations (NGOs) involved in promoting these policies, and how this has (or has not) affected

Karimojong healers. Second, I examine how Karimojong mothers themselves are healthcare providers and their therapeutic decision-making processes for child illnesses. Finally, I describe the Karimojong folk taxonomy for indigenous healers which identifies practitioners along a continuum from initiated medico-religious healers to uninitiated medical specialists.

Chapter 8 examines how structural violence has impacted Karimojong livelihoods, health, and well-being. This chapter addresses normalcy as a coping mechanism in which the Karimojong explain child deaths, ill health, and misfortune. Using the concept of the mindful body (Scheper-Hughes and Lock 1987) I analyze Karimojong ethnomedicine through illness experiences at the individual level, the embodiment of suffering at the community level, and the political and economic conditions that have shaped Karimojong ill health and limited their healing methods. This chapter summarizes the findings and limitations of the study and concludes with recommendations for future research.

Chapter 2 Study Population

“Karimojong Struggle to Survive Amid Famine” –The Monitor 6/20/09

In the remote Karamoja region of northeastern Uganda, pastoralist herding communities struggle for survival amidst frequent drought, intercommunal cattle raids, and banditry (HRW 2007:2).

Nilotic Linguistic Group

The Karimojong, one of several agropastoral populations living in northeast Uganda, are members of the Eastern Nilotic language group, one branch of the Eastern Sudanic language family (Murdock 1959). Most Nilotic groups practice some form of pastoralism – agropastoralism, transhumant pastoralism, or nomadic pastoralism – or have pastoralist ancestors (Smith 1992). The Eastern Nilotic linguistic branch of Murdock’s (1959) scheme comprises primarily pastoralist populations living in northern Tanzania, Eastern Uganda, and Western Kenya. This branch includes Murdock’s Karamojong Cluster and the following groups: Jie, Turkana, Teso, Toposa, Nyangatom, Dodoth, and Karimojong (Dyson-Hudson 1966, Gray 2000, Gulliver 1955, Gulliver 1956, Lamphear 1992). Some researchers (Gulliver 1953, Knighton 2005) denote an inclusive, geographical term, *Karamojong*, for the three populations – Dodoth, Jie, and Karimojong – residing in northeast Uganda.¹ The Karamojong, however, are heterogeneous with each group having its own cultural values, practices, languages (yet mutually intelligible), and social organization (Gulliver 1953).

¹ In contrast, Baker (1981) classifies just one tribe as the Karamojong and lists the Dodoth and Jie as separate groups. Here, I use the term Karamojong to refer to the Nilotic groups of Uganda (Dodoth, Jie, Teso, and Karimojong).

The focus of this dissertation is solely on one group, the Karimojong (with an “i”), which represents ten territorial sections (Table 2.1). The British government only officially recognized the three largest Karimojong sections—NgiBokora, NgiMaseniko, and NgiPian—and named the newly formed administrative counties accordingly (Bokora, Matheniko, and Pian).

Table 2.1: Karimojong Territorial Sections (Dyson-Hudson 1966, Novelli 1988)

NgaKarimojong Territorial Sections
NgiBokora (Bokora): the partridge people
NgiMaseniko (Matheniko): the bull people
NgiPian (Pian): the spirit or lighting people
Ngitome: the elephant people
Ngimosingo: the rhinoceros people
Ngipei: the wild dog people
Ngimuno: the snake people
Ngikosowa: the buffalo people
Ngikaleeso: the ostrich people
Ngimogwos: the people from the hill Mogwos

Karamoja’s Origins

Today Karamoja District does not exist as an administrative unit; however, researchers and locals continue to refer to Uganda’s northeast corner as Karamoja. Five administrative districts now form the region (Figure 2.1). These districts—Kaabong, Kotido, Abim, Moroto, and Nakapiripirit—encompass an area of 27,200 square kilometers, are the homelands of almost one million residents,² and are the

² This figure, according to the 2002 census, is divided accordingly: 379,775 Kaabong; 157,765 Kotido; 58,590 Abim; 170,506 Moroto; 153,862 Nakapiripirit. Kaabong and Abim were created from Kaabong district after 2002, but their population figures are extrapolated from the census data.

poorest districts in Uganda (HRW 2007, Mkutu 2007, Stites et al. 2007, Stites, Mazurana, and Akabwai 2007). This area encompassed the wet and dry season grazing territories of several Eastern Nilotic pastoralist groups.

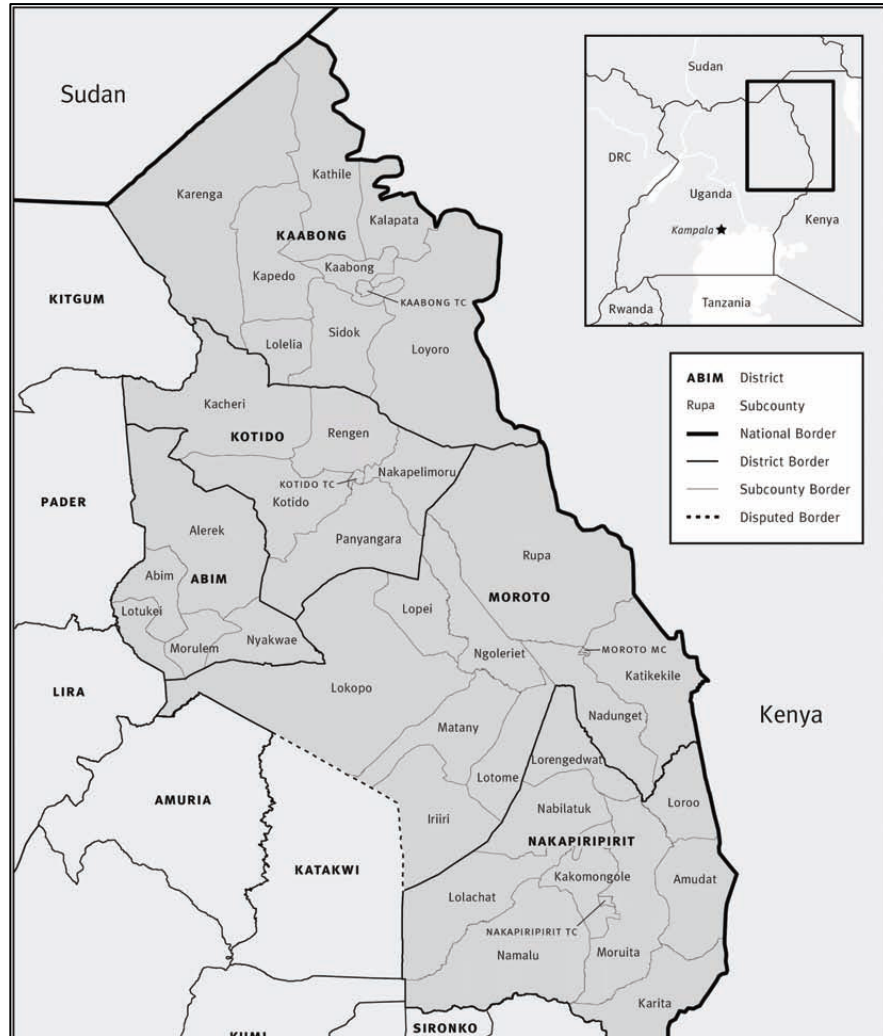


Figure 2.1 Districts of Karamoja Region (HRW 2007:1)

Initial Colonial Policies: Segregating Karamoja

Uganda became an official British Protectorate in 1894; however, it was not until 1897 that British officials traveled to Karamoja. By this time, Karamoja had undergone three successive years of hardships: a serious rinderpest epidemic that

killed nearly half the cattle population in 1894; a locust invasion in 1895; and a drought in 1896 that decimated crops (Baker 1977). Colonial administrators divided land based on European notions of owned space, not according to pastoral realities (Barber 1968, Gray 2000, Gulliver 1953). The newly formed province, which bound pastoralists to arbitrary administrative districts, reinforced pastoralists' economic and geopolitical isolation from the rest of Uganda. The cyclical migrations of the Karamojong are very similar to the survival strategies of Nilotic groups living in Kenya and Sudan, but very different from other regions of Uganda (HRW 2007).

Residents of Karamoja still encounter adverse effects from the colonial relationship. According to Nsibambi and Byarugaba (1982), the aim of the colonial administration was to extract resources with minimal costs, but in reality the costs were high. As Baker (1977:155) noted, "the rate and scale of change during colonial times was more than the indigenous system could absorb." Furthermore, British colonial policies stood in stark opposition to pastoral interests and aimed to remove pastoralists' dependence on cattle (and thus, their livelihoods as well as their cultural traditions) through a three-pronged approach. First, the British attempted to control livestock raiding and halt the arms trade. Second, colonial policies replaced the pastoral system with settled agriculture and ranching schemes. Third, the British used indirect rule throughout their colonies. The British modeled their implementation of indirect rule in Karamoja after a fairly successful implementation in southern Uganda in which the British adopted the hierarchical clan system of the Buganda kingdom (Nsibambi and Byarugaba 1982). In contrast, Nilotic pastoralists

did not have a corresponding indigenous system of centralized authority; thus, the British imposed the notion of chiefs on the Karimojong (Dyson-Hudson 1966, Novelli 1988, Pazzaglia 1982). Each of these methods to control the locals has caused tension and violence between the pastoralists and the government, as well as among the pastoralists themselves.

Major MacDonald led the first documented British military expedition to Karamoja in 1898 (Barber 1968, Barber 1962, 1964a, b, Langlands 1971, Pazzaglia 1982). The purpose of MacDonald's expedition was two-fold (neither objective had any concern for indigenous Karamojong groups): 1) to reassert Anglo-Egyptian control north of Karamoja; and 2) to take control of the Nile River over other European colonizers (Barber 1964b). But, because the British deemed Karamoja a poor economic investment, the colonial administration declared there was no need for British rule in Karamoja "until such time as the permanent occupation of their country becomes a necessity" (Barber 1962:111). From 1897 to 1911 the British government had little interest in Karamoja beyond the ivory trade; the presence of traders and hunters peaked during this same time due to Karamoja's sizeable elephant herds (Barber 1968, Barber 1964a, Dyson-Hudson 1966, Pazzaglia 1982). Fifty-six trading posts where merchants exchanged cattle or guns for ivory (two head of cattle bought two elephant tusks) existed in Karamoja by 1903 (Mamdani, Kasoma, and Katende 1992, Pazzaglia 1982, Wabwire 1993). The ivory trade had at least two devastating impacts. First, elephants no longer roam Karamoja outside designated parks; and second, guns became widespread in the region (Barber 1962).

Because lawlessness and unchecked cattle raids reigned (most likely a result of the ivory trade), the British government could no longer ignore the administration of law and order in Karamoja (Barber 1968, 1962, 1964a). Captain Tanner (a district superintendent of police) was dispatched to Karamoja specifically to halt raiding between the Karimojong and Pokot tribes. This event corresponds to the first recorded year (1909) in the Karimojong local event calendar,³ *Semei Kakunkulu*, and marks a noteworthy event in the memories of the elders, who recalled that Tanner brought the region under colonial rule. Captain Turnell, accompanied by a battalion of the King's African Rifles (KAR), was stationed in Karamoja as the first British administrative officer in 1911 (Akol and Gray 2009, Barber 1964a, Pazzaglia 1982).

One measure taken to combat the flow of guns into the district was to seal Karamoja's borders (Barber 1964a). In July 1911, the British demarcated Karamoja as a "closed district," keeping all nonpastoralists and all but a few British soldiers out of the region (Akol and Gray 2009, Gray 2000). Traders, British officials, and neighboring pastoralists (even those who claimed the area as part of their ancestral territory but who were not in Karamoja at its date of closure) were unable to enter Karamoja without governmental approval (Pazzaglia 1982). The sign "YOU ARE NOW ENTERING KARAMOJA CLOSED DISTRICT. NO VISITOR MAY ENTER WITHOUT AN OUTLYING DISTRICTS PERMIT" was posted at all borders

³ Akol and Gray (2009) collated the Karimojong local event calendar for the Bokora and Matheniko territorial sections. They interviewed Bokora and Matheniko elders to calibrate culturally named and recognized seasons or events with the Gregorian calendar. I relied heavily on the Karimojong event calendar during my tenure in Uganda and added updates, specifically events from 2000 to 2006. Appendix C includes these updates to the original local event calendar.

(Brasnett 1996:31, Muhereza 1999:12). The British said these actions were designated to end raiding; however, the Protectorate Government was a primary provider of weapons and “ran illicit consignments of arms, and fostered fighting between tribes when it was in their interest to do so” (Dyson-Hudson 1966:7).

The colonial government appointed the KAR to patrol the region from 1912-1914 and to strictly enforce the borders (Dyson-Hudson 1966:7). The military presence drastically constrained the range of Karimojong migrations, which proved to be particularly deadly during the dry season when cattle needed to travel long distances to reach available grass and water (Pazzaglia 1982:117). Further, British ordinances were enforced using brute violence, including the burning of agricultural villages and physical abuse of local people (Baker 1977:156). For instance, the colonizers “proceeded to do so by shooting the people, burning their huts and seizing their livestock” (Mamdani, Kasoma, and Katende 1992:25).

In 1914 the KAR withdrew from the current Ugandan-Kenyan border and a colonial police force, under ASP Turpin, was put in place.

Turpin asked much of his subordinates, recruiting porters and other labourers compulsorily, fining those who resisted, demanding larger numbers of cattle, and even setting villages on fire and ordering the execution of particular individuals. The Karimojong called him Lokijukwa, the one who pushes (Pazzaglia 1982:61).

Turpin extended his security work to include civil administration through the creation of two police posts and established Karamoja’s headquarters in Moroto Town. The Karimojong refer to this time as *ekaru angolebei* (the year of the servants) because women were required to provide thatch and construct Moroto’s

administrative buildings (Akol and Gray 2009). Turpin also used Karimojong laborers to build Moroto Town as well as to construct military roads connecting the town to trading centers throughout the region (Baker 1977, Barber 1962, Pazzaglia 1982).

By 1916 the British had appointed 58 chiefs to the Karimojong tribe alone. Of these, seven were “major chiefs” who had the responsibility of policing and taxing fellow Karimojong. Major chiefs from all of Karamoja formed the highest rank of local command – the Central Karamojong Baraza – which operated under the Karamoja District Commissioner’s leadership. Because the administrative system and treatment of insubordinates was not compatible with indigenous political authority, conflict erupted and resulted in the deaths of numerous chiefs (Akol and Gray 2009). In turn, this sparked additional forcible regulations by the British government (Dyson-Hudson 1966).

Becoming a Province: Change the Pastoralists

In 1921 Karamoja officially became a province with a civil administration under Ashton Warner (Akol and Gray 2009, Baker 1977, Barber 1968, Barber 1964a, Pazzaglia 1982); however, Karamoja Province lacked many of the civil services, governmental institutions, and infrastructure already in place in Uganda’s other regions (Dyson-Hudson 1966:8). This disparity continued with the civil government only maintaining the minimal administrative functions that military rule had established (Baker 1977). “Karamoja was to be distinguished from the remainder of the [Uganda] Protectorate not merely by its climate and geography, but by the aims

of government within it. For the next thirty years Karamoja was administered on a 'maintenance basis' (Barber 1962:119). Furthermore, becoming an official province within the protectorate administration did not make Karamoja's boundaries more open; rather, it increased the disparities between people living within Karamoja and those who lived elsewhere in Uganda. Pastoralist groups in the Karamoja District were contained within that region alone, even though their customary homelands encompassed a far larger and more fluid grazing area (Alnwick, Stirling, and Kyeyune 1985, Wabwire 1993). The British government effectively removed Karamoja from the rest of Uganda by maintaining it as a "no-go" zone.

The British increased their oppression of the Karamojong pastoralists, which fueled a growing tension between the indigenous populations and the colonial administrators. First, Turpin executed a well-known local prophet, causing widespread outrage. Second, in 1921 the government prohibited livestock migration to dry-season grazing lands unless herders obtained prior permission from the Karamoja District Commissioner. The fee for illegal migration was four head of cattle, a relatively expensive fine (Dyson-Hudson 1966:15). In addition, men were prohibited from migrating unless they first worked in road maintenance or filled a communal food granary. Third, the colonial government established a poll tax beginning in 1916 and then raised it in 1922 and again in 1923 (Akol and Gray 2009). To pay, Karamojong men had to sell or trade cattle to obtain the necessary cash (Baker 1977:158). Fourth, the British imposed a quarantine center to reduce livestock diseases (Novelli 1988). Fifth, the British reduced indigenous grazing zones by

allocating the land to competing groups and establishing forest and game reserves where grazing was prohibited (Opuli-Watum 1980). For example, the Protectorate of Kenya incorporated 15 percent of Karamoja's land between 1920 and 1940 and an additional 25 percent of Karamoja was demarcated as a national park in 1940 (Jabs 2007:1510, Mamdani, Kasoma, and Katende 1992, Muhereza 1999). Authorities also granted the neighboring Teso tribe of Uganda a portion of the fertile agricultural land in western Karamoja, whereas a separate administrative county was formed for the Pokot tribe that gave them the "most prized dry-season grazing zones of the Karimojong" (Baker 1977, Dyson-Hudson 1966:18).

Although all of these actions oppressed the Karimojong groups, cattle destocking was by far the most detrimental to the pastoral livelihood. The Karamoja Native Administration Cattle Trading Scheme (also known as the Karamoja Cattle Scheme, or KCS) was the first institutionalized cattle-marketing program in Karamoja. KCS first began in 1941 to supply military forces with a steady source of meat collected via weekly quotas from county chiefs in Karamoja. After World War II, KCS was extended to address three goals, all of which aimed to remove cattle from the pastoralists. First, the colonizers proclaimed their desire to stop environmental degradation caused by overgrazing, and exporting Karamoja's cattle out of the district was one measure to do so. Second, KCS would finance the local colonial administration through the cattle sales, and, finally, KCS beef would supply military forces and urban industrial populations with a steady source of meat (Quam 1978:56). KCS, therefore, was another means to remove the pastoralists' cattle. The

government created a cattle-buying post; however, KCS was the sole buyer. KCS, thus, became the most profitable source of colonial revenue in Karamoja and was greatly resented by the locals (Baker 1977, Mamdani, Kasoma, and Katende 1992, Muhereza 1999). Sales from KCS underwent turbulent times due to cattle disease epidemics and profits declined toward the end of its second decade in existence (Quam 1978).

Karamoja's residents were discriminated against and stereotyped as "primitives" and "savages." The colonial regime encouraged these practices through its discriminatory and paternalistic language, which can be found in many reports from district officers. Here, I include examples from Captain Persse's (1934) article "Ethnological Notes on the Karimojong" and AJ Docherty's (1957) article "The Karimojong and the Suk." Captain Persse (1934:114) wrote "[in regard to] the esoteric beliefs of a primitive tribe. One is liable to meet with a veil of concealment and evasion and to be fobbed off with inaccurate and lying information." Docherty's (1957) work exemplifies the European prejudicial notion of the "African primitive." In his description of colonial efforts to curtail cattle raiding, Docherty praised three policemen who shot warriors armed with spears, "Men like these are to be admired" (ibid:32). These officers, in fact, received a medal of honor, presented by Queen Victoria during her visit to the Ugandan Protectorate. Docherty described the Karimojong consumption of cow's blood as a nauseating cultural practice and characterized them as being uncouth due to their lack of cloth garments. He explained that former Karimojong prisoners often asked to keep their uniforms upon

discharge, but the “answer to this extraordinary request has always been the same — ‘Naked you came and Naked you go.’ A very sensible attitude, I submit, as these people are still comparatively unsophisticated” (ibid:38). Dyson-Hudson (1958) took issue with these claims and corrects some of Docherty’s descriptions of Karimojong cultural practices, but failed to address the paternalistic language of the colonizers.

Karamoja Resettlement Scheme

The Karamoja Resettlement Scheme (1955-1958), also known as the Karamoja Rehabilitation Scheme (Wilson 1973), was the colonial government’s last effort to develop Karamoja before Uganda’s independence. This program, in theory, was intended to mend the injustices accrued by closing the district’s borders. The scheme’s operational methods sparked debate between scholars and British officials who believed that Karamoja’s populations and subsistence strategies should have been preserved and others who thought Karamoja should have been pushed into modernity through cattle destocking and the implementation of agriculture (Fleay 1996:21). This resettlement scheme designated approximately \$85,000 for the development of new water supplies and the introduction of “more progressive methods of land use” (i.e., farming or meatpacking plants) (Cleave 1996:36).

In addition, the scheme allocated money for paid laborers, porters, and drivers. Wilson (1973:82) linked the introduction of Karimojong into governmental service positions to more men wearing “cotton shorts” (i.e., the Karimojong began to accept Western dress). Wilson’s article clearly advocated for more governmental involvement in Karamoja and employed language that reinforces the importance of

“modernization of the primitive peoples” without mentioning the hardships the Karimojong endured at the hands of either the British or Ugandan administrations.

One former district officer recalled:

Until the late fifties, Karamoja remained a backwater in terms of economic, social and political development, well behind the rest of the country. This caused increasing criticism, and government was accused of neglecting the district and treating it as a ‘human zoo’. In response, government tried to bridge the gap. Ample funds and staff were produced to implement an ambitious development scheme based on animal husbandry and water supplies, but also covering other services – health, education, and so on (Cleave 1996:31).

The British government created the Special Regions Ordinance of 1958 in which Karamoja was to be classified as a “special region” after independence due to its “primitive” state (Alnwick, Stirling, and Kyeyune 1985, Bataringaya 1961, Wabwire 1993). The Special Regions Ordinance failed because it focused on the seizure of cattle as a means to deal with cattle raiding and lawlessness, which had increased in the late 1950s as independence loomed. The soon-to-be Ugandan administration rejected this ordinance and commissioned a separate modernization project instead. Two resulting works – The 1961 *Report of the Karamoja Security Committee* (Bataringaya 1961) (also known as the Bataringaya Report) and the 1963 Ugandan Administrative Bill – defined how the Government of Uganda (GoU) would implement Karamoja’s policies until 1967 (Wabwire 1993).

The Karamoja Security Committee visited all county headquarters (except Labwor) in Karamoja to assay raiding-control measures. The Karamoja Security Committee declared that uncontrolled raiding, if left unchecked by colonial administrator, would lead to constant warfare. Language within the Bataringaya

Report was belligerent. For instance, because pastoral warriors did not accept local chiefs, the colonial government should enact “holy terror” to make them abide by administrative rules (Bataringaya 1961:14, Mkutu 2008, Wabwire 1993). The Bataringaya Report (1961) concluded that the Karamojong people were the cause of the region’s “backwardness” and that a “firm hand” should be used to “modernize” them. The report specifically stated that “primitive people must be closely and firmly administered if they are to keep law and order” (Bataringaya 1961:7).

The Bataringaya Report also advocated that Karamoja be designated “under emergency” in which a complete overhaul of military control was necessary to halt raiding and to enact rapid development of the region. First, the committee recommended that all KAR troops, police, and tracker forces undergo military training in “jungle warfare” and be armed with automatic weapons. Second, the report endorsed the transition of Karamoja’s cattle economy to a cash economy. To do so, the security committee suggested that a meat-canning factory, a slaughterhouse, and a tannery be built in Karamoja to entice the pastoralists to give up their nomadic and warrior ways (Bataringaya 1961:27). Once again military might was recommended to force the pastoralists to relinquish their way of life. Although the Bataringaya Report criticized existing efforts, such as the Special Regions Ordinance of 1958 and the Karamoja Cattle Scheme (KCS), the report did not provide details about how their own initiatives would stimulate a cash economy. In addition to the livestock processing centers, the committee also proposed that settled agricultural programs be enhanced to encourage Karamojong to decrease

their migratory nature. The security committee believed that nomadism was the leading reason previous efforts to introduce administrative laws failed, because the Karamojong could easily flee police into the bush. Finally, the committee suggested improved infrastructure, mandatory education for at least one child per family, and a complete replacement of all chief and administrative employees. The committee concluded, "If Karamoja is to cease to be the problem that it is now, the pace of development must be forced and forced hard, and if this is to be done, it should be NOW or NEVER!" (Bataringaya 1961:15).

Karamoja's district commissioner from 1958 to 1964, Cordery, adhered to the Bataringaya Report (1961) and used military force to "solve" tribal conflicts. First, Cordery used KAR troops to enforce strict blood cattle taxation, in which any local accused of murder had to give a set number of cattle to the grieving family. Second, on May 17, 1962, Cordery sent the KAR to impound spears, which the pastoralists used during cattle raids (Baker 1981). The de-spearing campaign was a model for the current disarmament program in the region. During implementation, KAR surrounded villages with troops and fighter helicopters to remove cattle and weapons and killed at least 60 people. This exemplifies how the government (both colonial and postcolonial) has repeatedly treated Karamoja's residents. Programs the government sponsors, such as biomedicine, are still viewed with suspicion by pastoralists due to years of discrimination, injustice, and abuse.

The flaws in the development schemes were made more apparent by the succession of droughts and floods. Tensions increased among Uganda's pastoralists,

both within Karamoja and among those living in neighboring districts who competed for resources made even more scarce by the administrative policies that were irreconcilable with the ecology of the region (Baker 1977).

Postcolonialism: New Rulers, Old Rules

In 1962 Uganda became an independent state; however, the oppressive policies of the British remained in place in Karamoja. For instance, the 1963 Ugandan Administrative Bill proposed that a special military police force be created to enforce cattle-destocking programs in an effort to “modernize” Karamoja (Wabwire 1993). “The militaristic colonial approach involving seizures of livestock seems to have continued in post-colonial Karamoja” (Mkutu 2008:125). The special force’s main goal was to decrease the incidence of cattle raids, but the opposite occurred. Limited rangeland and scarce resources heightened tensions among competing pastoralists and fueled the need for additional cattle raids to replace lost livestock. Destocking also took the form of taxation, which required the payment in cash; herders often had to sell cattle to pay their taxes (Opuli-Watum 1980). In 1963 (*ekaru a mukuki*, “year of the spear” or *ekaru a nagilgil*, “year of the helicopter”) soldiers confiscated spears during homestead raids and used helicopters to seize large numbers of cattle (Akol and Gray 2009, Gray 2000).

Widespread famine struck Karamoja from 1965 to 1967. The Karimojong refer to this time as *Logotho* (from the NgaKarimojong word, *egogwos*, “luggage”) because there was so much hunger in the Bokora section that people migrated elsewhere (Akol and Gray 2009, Gray 2000). The GoU distributed aid relief, but only

to those individuals who did not own cattle (Baker 1977:167), which was another brutal political act to get the pastoralists to give up their cattle. The GoU directed that people with cattle should not receive food relief because those individuals could sell their animals in exchange for food.

The 1968 Resettlement Scheme was the next expression of an established theme: forcing migrant pastoralists to become non-nomadic agriculturalists. This resettlement plan sought to increase agricultural production in the fertile land of western Karamoja, increase security and police patrol, and control livestock production (Mamdani, Kasoma, and Katende 1992:48-50). During the 1968 scheme, all of Karamoja was to be resettled into areas that were limited to 200 people, 700-800 stock units (one stock unit was equivalent to one head of cattle or six goats or sheep), and 200 acres of agricultural land, which was to be farmed on a rotation basis. Mamdani and colleagues (*ibid*) argued that this plan was destined to fail from the outset. First, livestock herds would need to have been drastically reduced to meet the stock-unit-to-acreage allowance. Second, rainfall alone in Karamoja could not support the increase in agriculture; therefore, the land required an irrigation system, a key item lacking in the resettlement plan. Finally, the administrative system was not in place to move the plan beyond paper; but when this proposal met resistance, the Ministry of Regional Administration ordered that all chiefs in Karamoja be replaced.

In 1971 Idi Amin became Uganda's third president in a military coup. Maladministration defined Amin's tenure; and governance of Karamoja during this

time (1971-1979) was nonexistent (Nsibambi and Byarugaba 1982:81). For example, the minister of mineral and water resources drilled 3,000 boreholes in Karamoja during the decade prior to Amin's regime. Amin's administration, however, did not maintain these boreholes; in fact, Nsibambi and Byarugaba (1982:90) found only 1,000 boreholes that worked in the 1980s.

Amin decreed that all residents of Karamoja must be "pushed" into the 20th century. He proposed a de-spearing campaign as the first step to force "modernization." Second, Amin required that pastoralists don Western clothing to cover their "primitive" state (Gray 2000, Mirzeler and Young 2000, Nsibambi and Byarugaba 1982, Verswijver 2004, Wilson 1985). The Karimojong recall 1971 variably: *ekaru ka Amin* (the year of Amin); *ekaru alacia Amin ngitunga* (the year Amin stripped people); *ekaru amunyarere ngitunga a Nawaikorot* (the year people were slaughtered at Nawaikorot; and, finally *Kolera* (for the cholera epidemic at the time) (Akol and Gray 2009). In April 1971, Amin's administration mandated that the Karimojong had to replace their animal-hide attire with cloth and maintain "unelaborated hair styles." In resistance to Amin's mandate (Akol and Gray 2009),⁴ the Karimojong donned their finest garments—hide skirts and front apron capes, beaded jewelry, and highly decorated coiffures—and marched to Nawaikorot to meet Amin. Amin's soldiers brutally stripped the Karimojong, forced women to

⁴ Verswijver (2004) has interpreted this event as a misunderstanding in which the Karimojong donned their traditional regalia in an attempt to impress the President of Uganda during his visit to Karamoja.

remove their metal wedding necklaces, and broke their glass beads.⁵ Worse yet, the troops gunned down the Karimojong at Nawaikorot and buried them in a mass grave. Wilson's statement reflects the dominant thinking at the time: "The Government *understandably* felt that Karamoja district should cease being a museum of the past and come into the twentieth century like the rest of the country" (Wilson 1973:81, emphasis mine).

Once Amin's regime collapsed, Karamoja residents revolted against years of repression and used any means at their disposal to replenish lost livestock herds. In 1979, during Milton Obote's military coup, Ugandan soldiers fled from army barracks in Moroto District, leaving a bounty of AK47s (Gray et al. 2003, Ocan 1994, Okudi 1992, Robinson et al. 1980, Sundal 2002, Wilson 1985). The Karimojong refer to this year as *ekaru abwanguniata NgiMatheniko ngatomina* (the year the Matheniko raided the guns) (Akol and Gray 2009). The impact of the increased availability of automatic weapons and armed cattle raiding is discussed in more detail below.

The period between the end of Amin's rule and the beginning of the current administration was simply more of the same. "Successive governments have also marginalized the area, leaving it with the lowest development and humanitarian indicators in Uganda, weak governmental institutions, and little support for alternative livelihoods" (HRW 2007:9). Overall, Karamoja has been marginalized not only by its geographic location far from the central business zone in southern

⁵ Karimojong now wear plastic beads or small glass beads. The large glass beads that were crushed "into dust" by Amin's soldiers were highly valued by the Karimojong. Those who were able buried their beads underground for safekeeping. In 2006-2007 I saw few ornaments made from large glass beads.

Uganda, but also because of its semi-arid environment which supports few subsistence methods other than transhumant pastoralism (Gray 2000, Gray, Leslie, and Akol 2002, Nsibambi and Byarugaba 1982).

Missionary Efforts

Missionaries first reached Karamoja's borders in the early 1900s but did not establish official posts until 20 years later (Novelli 1988). The colonial government encouraged and invited missionary posts in an effort to build schools in the region (Novelli 1988). For example, the Bible Church Missionary Society (BCMS) of the Anglican Church obtained permission to extend its work into Karamoja in May 1923. Although the BCMS' first missionary post, stationed in Lotome, only remained active for a few months, by 1930 they had built several schools (Novelli 1988, Pazzaglia 1982). The Italian Verona Fathers have maintained a continued presence in Karamoja since they first visited the region in February 1933 (Akol and Gray 2009, Pazzaglia).

Missionaries have developed, financed, and implemented educational and religious programs and are one of the main providers of biomedical services in Karamoja. Beyond that, they distribute international aid and food relief. FBOs began directly giving aid to the Karimojong during the 1960s. At first the missionaries only distributed small quantities of food, but during the disastrous famines of the late 1970s and 1980s, international aid involvement (from other NGOs and missionaries) peaked with "thousands of tons of food" (Novelli 1988:137). The Verona Fathers, in fact, were the first to report a widespread famine – the Great

Famine of 1980 (*Akoro*) – in an effort to attract international attention. Following the Verona Fathers’ plea for assistance, international NGOs established eleven relief centers and three subcenters to rehabilitate malnourished children and distribute relief food. After 1980, international aid agencies formed a near-permanent presence in the region. The aid is not without critique, however, and some scholars (Cisternino 1985, Okudi 1992) suggest their presence has undermined the indigenous economy and made the pastoralists dependent on foreign aid.⁶

Bokora and Matheniko: Karimojong of Moroto District

By 1958 Karamoja was divided into three administrative counties and 13 subcounties. This separated settled homesteads and grazing land without adhering to historic practices. “It is not surprising that this three-County system should have made little sense territorially, to a society that recognizes a permanent settlement zone distributed among ten territorial sections and an extensive outer margin of grazing land free to all” (Dyson-Hudson 1966:12). After independence, the GoU partitioned Karamoja Province into two administrative districts: Kotido District to the farthest north, and Moroto District, which was then further sectioned to form Nakapiripirit District from its most southern portion (Pazzaglia 1982:75). By 2006 Kotido District had been redrawn into three districts: Kaabong, Kotido, and Abim. Although the creation of new districts offers additional governance for Karamoja (i.e., additional administrators and infrastructure such as biomedical health units and schools) the repeated geopolitical reconfiguration stokes tension. New

⁶ The causes and effects of the Great Famine have been widely discussed elsewhere (Alnwick 1985, Biellik and Henderson 1981, Cisternino 1985, Dodge and Wiebe 1985, Gray 2000, Knutsson 1985, Okudi 1992, Robinson et al. 1980, Sundal 2002).

administrative boundaries reify ethnic divisions and create additional barriers for peaceful migration into neighboring districts.

Moroto and Nakapiripirit Districts overlap with the historical homelands of the Karimojong. In fact, Moroto District's two counties have the English names of two of the Karimojong territorial sections, Bokora and Matheniko, whereas Nakapiripirit contains Pian County (the third territorial section). According to the 2002 census, Moroto District has a low population density with 22 persons per square kilometer (compared to the national average of 124 persons per square kilometer). Presently, Moroto District is a mixture of rural homesteads and semi-urban communities. Moroto Town, the administrative headquarters in Matheniko County, has a government-run hospital, a food market to which fruits and vegetables are imported from neighboring districts, hotels, restaurants, and many shops. Furthermore, most NGOs working in the region are based in Moroto Town. Surrounding the town are semi-urban Matheniko homesteads where families participate less actively in agrarian subsistence strategies and earn wages through brewing beer or selling their labor. Radiating out from the town are more rural homesteads in which residents adhere more closely to agropastoralism.

In Bokora County, the main trading center (Matany) has several small shops, outdoor stalls, St. Kizito Hospital and nursing school, a large Catholic church and compound, and a primary school. Matany is home to numerous residents who have built extensive neighborhood settlements surrounding the area. Moving out from

Matany, villages are more rural but may be a short walking distance to small biomedical clinics, schools, and trading centers.

Ecology

Moroto District has three distinct topographical zones, each with differing vegetation, soil composition, rainfall accumulation, and, therefore, subsistence strategies. The ecological zones range from the rocky highlands along the Ugandan-Kenyan border, where most residents adhere more strictly to pastoralism, to the plains, where the land is more fertile and able to support limited agriculture. Agriculture alone, however, cannot be ecologically maintained in this region due to unpredictable, variable rainfall (Gray 2000).

Average annual rainfall in Karamoja ranges from 500 to 700 millimeters, but it varies both temporally and spatially (Mamdani, Kasoma, and Katende 1992:2). Karamoja is both the driest area in Uganda and has the longest dry season (at least six months) (Nsibambi and Byarugaba 1982). In fact, rainfall is highly erratic and localized. During the wet season, intense downpours wash away seeds and crops, turn the soil into heavy, sticky mud, and flood rivers (Knighton 2005). In contrast, the dry season is prone to intense droughts with water at times available only at 20 meters underground (Dyson-Hudson 1966). Multiyear droughts and short-term flooding severely limit the agricultural potential and contribute to periodic widespread famine. In good years, rainfall may be sufficient enough to provide large agricultural yields; however, other years the rains are too heavy or too little and crops fail (Gray 2000). Five out of six agricultural plots fail in Karamoja, and it is

often necessary to replant crops at least four times (per agricultural season) to accrue any yield (Baker 1977:154, Novelli 1988). Gray (2000:402) reported that Moroto experienced one drought every three years, with seven drought years occurring between 1979 and 2000. These figures may actually be on the rise; droughts have prompted the World Food Program (WFP) to distribute relief food each harvest season since 2005. The 2008 drought was reportedly so severe that the Karimojong experienced food shortage which prompted the GoU to declare Karamoja under a food emergency in February 2009 (IRIN 2009). Drought and hunger have dominated life in Karamoja since the 1990s.

Combined subsistence strategies

Transhumant agropastoralism – the seasonal migration of livestock between lowlands and highlands while cultivating a few select crops at semipermanent homesteads – has proven to be the best subsistence strategy for Moroto (Gray 2000, Gray, Leslie, and Akol 2002, Knutsson 1985). Although the Karimojong still consider themselves to be people of cattle, many Karimojong today are completely dependent on agriculture or other economic strategies.

The Karimojong's main agricultural product is sorghum, but they also plant cucumbers, beans, gourds, maize, a variety of greens, and melons. As previously mentioned, settled agriculture alone is an unreliable livelihood. "Karimojong have only a less-than-even chance that the work of cultivation will be rewarded by a good crop or better; one chance in three that the crop will just save them from hunger; and one chance in four that the work involved in the gardens will prove to have been a

complete waste of effort” (Dyson-Hudson 1966:42). To combat the precariousness of agricultural production, the Karimojong collect wild fruits and green vegetables, hunt wild game, and most importantly, keep diversified livestock herds (Dyson-Hudson and Dyson-Hudson 1969). The Karimojong ideal is to maintain a large herd consisting of cattle, sheep, goats, donkeys, and occasionally camels (Dyson-Hudson 1966, Dyson-Hudson and Dyson-Hudson 1970). Different types of livestock feed on different flora, thus, the risk of complete animal loss is reduced because the livestock species are differentially vulnerable to drought, and diseases generally are species-specific. Further, a diversified herd helps ensure a year-round supply of the main subsistence element – milk – because cattle and goats give milk at different times of the year (Mamdani, Kasoma, and Katende 1992).

In the past, the Karimojong divided their livestock and human resources between two settlement patterns: semipermanent agricultural homesteads in which the women, children, and the elderly resided along with a few milking animals, if available; and temporary mobile cattle kraals for adult men, visiting women and children, and the majority of the livestock (Dyson-Hudson 1966). At the semipermanent settlements, households were grouped together according to kinship (Figure 2.2). Named after the elder patriarch, a Karimojong homestead (*ere*) is a circular enclosure made up of numerous households, separate enclosures for sheep and goats, and a communal corral located in the center for all cattle of the homestead. The homestead ideally is home to the senior man (the homestead’s namesake), his wives and their children, and his adult sons, their wives, and their

offspring. The Karimojong are polygamous and one man may have several wives; if the wives are officially married (through the transfer of a bridewealth payment of livestock and goods to the woman's family), they all live in separate yards (*ngikalia* or *ekal*, singular) in the husband's "side" of a single homestead.



Figure 2.2 Aerial Photograph of Karimojong Homestead
(Photo credit: www.karamoja.eu)

Although the Karimojong trace their lineage patrilineally and tend to live patrilocally, the yards are the domain of women. Women construct all aspects of their yard, including their mud and grass-thatch hut, their wood fences, and day-shelters. A woman's yard may also contain a small area for a kitchen garden in which she plants vegetables. Women's yards are separated from one another with fences, and those along one section form a side of the homestead. A side should contain the yards of co-wives, but in practice this is not always the case. Two or more sides encircle a large, common cattle corral to complete the homestead. The

size and composition of homesteads vary widely. For example, the norm is for sides and households to be linked patrilineally, but some husbands move to their wives' communities, and some homesteads have recently been forced to join together for increased protection against armed cattle raids. The range of a homestead is 50 to 150 households (Muhereza 1997). Karimojong neighborhoods of approximately 13 homesteads cluster together around a particular sacred ground (Dyson-Hudson 1966, Knighton 2005). More homesteads today band together and are closer to trading centers and towns (Stites et al. 2007). Outside the homesteads are large agricultural plots for each woman's sorghum gardens – these gardens are usually located within a woman's neighborhood.

Migration of livestock between dry season grazing lands and agricultural homesteads maximizes water and fodder availability and is the key to livestock survival (Gray 2000, Muhereza 1999). During the dry season, men move their livestock to areas of short-lived grasses and permanent water sources. After the wet season when the crops have been harvested, men return with their cattle to the homesteads where the animals eat the nutritionally rich sorghum stalks and have access to ephemeral water holes (Mamdani, Kasoma, and Katende 1992). Although more men than women live at the kraals, women can and do live at the cattle camps for extended periods of time (Stites et al. 2007). For instance, women and children who are identified by their families as being the most nutritionally deprived, join their men at the kraals where they have access to the cattle's blood and milk. Alternatively, men bring some livestock back to the agricultural homesteads when

the crops have failed. Both of these strategies are dependent on owning animals. Cattle kraals are designed to be highly mobile so that Karimojong men can move their camps frequently in search of water and forage while avoiding “enemies” (raiders) (Dyson-Hudson 1966). Because nomadic pastoralists consider grazing lands to be communal (according to territorial affiliation), groups compete for land and water resources during periods of low rainfall (Gray 2000, Knighton 2005).

Few economic opportunities beyond herding exist in Karamoja. One does find a variety of small shops, outdoor stalls, and other businesses owned and operated by Karimojong entrepreneurs in trading centers and towns. Although local markets exist throughout Karamoja, produce sold there is largely imported from other Ugandan districts (Stites et al. 2007). In addition, unskilled casual labor, ranging from unloading lorries at markets and shops to preparing and serving food and construction work, exists as well. These positions are relatively few and require strenuous work in exchange for very little pay. Finally, in towns and trading centers women also attempt to sell resources, such as charcoal and firewood, which they have harvested (ibid). Similarly to casual labor, the amount of work and effort a woman commits to gathering wood or burning charcoal⁷ and then carrying the loads several hours walking distance to sell or barter is hardly worth her effort.⁸ When

⁷ Men are typically responsible for the making and burning charcoal, whereas women carry large bags of charcoal to the towns and trading centers to sell. But, in 2007 some Karimojong women I spoke with reported they were solely responsible for both burning and selling charcoal.

⁸ In 2007 one large bag of charcoal sold at \$1.25-\$2.75, whereas a bundle of firewood earned approximately \$0.50. Stites and colleagues (2007:32) report similar prices for charcoal and firewood.

harvests have failed or animals have been raided, however, these meagerly paying jobs become families' sole sources of survival.

The Value of Cattle

"In great degree their possession [of cattle] determines social status, and there are few aspirations that do not depend on, or cannot be expressed in terms of, cattle ownership" (Dyson-Hudson 1966:101). For the Karimojong, cattle are not only equated with wealth but are both the medium of social interactions and the way a community's well-being is defined (Dyson-Hudson and Dyson-Hudson 1969, Knighton 2005). Cattle hold the highest value among the Karimojong and are incorporated into practically all social interactions. In fact, the Karimojong use cattle in the following ways: as a sacrifice to mark important life events; in trade; to build and reaffirm familial relations (such as bridewealth and to formalize paternity) and formal friendships; as food (the Karimojong consume the milk, fat, blood, and meat of cattle); for use during healing and prophetic rituals; and for everyday items made from all parts of the animals (for instance, horns may become snuff-holders, whereas a hide can become a sleeping mat) (Dyson-Hudson 1966, Sundal 2002).

In the late 1950s, Dyson-Hudson (1966) noted that "Cattle-less and cattle-poor families are infrequent, because a family can seldom be either started or maintained without a herd, for bridewealth and for food" (Dyson-Hudson 1966:50). This statement no longer holds true in Karimojong society, due to armed cattle raids, governmental destocking schemes, drought, and disease epidemics that have decimated livestock herds.

Armed Societies: Cattle Raiders and the UPDF

Cattle raiding in Karamoja has shifted from a communal activity to one of individual commercial gain or interest (Knutsson 1985, Mirzeler and Young 2000, Ocan 1994, Stites et al. 2007, Sundal 2002). In the past, cattle raids were used to redistribute wealth among groups in Karamoja, provide animals for brideprice, and extend grazing land rights (Cisternino 1985, Dyson-Hudson 1966, Gray 2000, Mkutu 2007, Stites et al. 2007). According to Gray (2000:402), raiding in Karamoja is ecologically based because pastoralism “depends on access to chronically scarce, unpredictable resources – access that varies dramatically as a result of extreme fluctuations in environmental conditions.” In the past, raids were typically larger both due to the weapons involved – spears required high proximity and many warriors to ensure success – and an adherence to a set of community rituals in which seers and elders both sanctioned the raids and blessed the warriors (Dyson-Hudson 1966). Novelli (1988:151) stated that “Once it was unthinkable to go on a raid without consulting the diviner (emuron) or having the blessing of at least some of the most important elders,” and that “Karimojong faith in elders has been replaced by their faith in the automatic weapons.” No longer do warriors need approval of elders or seers to sanction an impending raid with AK47s because raids can occur more readily and on a smaller scale (Cisternino 1985, Gray 2000, Jabs 2007, Mirzeler and Young 2000, Ocan 1994, Stites et al. 2007). Automatic weapons enable one or a few men to steal cattle because they can shoot (and kill) defenders with ease.

Two direct outcomes resulted from the widespread use of automatic weapons: the authority of elders has eroded; and Karimojong territorial sections now raid fellow Karimojong. First, the passage of power to the next generation of men strictly followed Karimojong generation and age-sets prior to the use of AK47s. Two cyclical male generation-sets – the elders who held political authority and the warriors who undertook elders’ wishes (especially regarding cattle raids) – were recognized by the Karimojong (Novelli 1988, Pazzaglia 1982). Each generation set was divided into five age-sets, which were determined by initiations and rights of passage (Dyson-Hudson 1966:163, Novelli 1988, Pazzaglia 1982, Stites et al. 2007). A Karimojong man could not contribute to assemblies until he had undergone initiation – until that time he was considered a boy no matter his age. The senior generation determined when the junior generation set would come to power through a succession ritual. This ritual occurred during years of bountiful harvests and peace, both of which are almost nonexistent now; thus, the last succession ceremony occurred between 1956 to 1958 and the delay in turning over power has heightened tensions among generations (Gray 2000, Stites et al. 2007:17).

Second, attacks against fellow Karimojong (i.e., Bokora raiding either Matheniko or Pian communities) were strictly forbidden in the past (Dyson-Hudson 1966, Nsibambi and Byarugaba 1982). Until the 1970s, the Karimojong sections aligned with one another, but due to failed harvests and increased access to automatic weapons, these alliances broke down (Ocan 1992, Okudi 1992, Pazzaglia 1982). By the 1980s raids among Karimojong sections became commonplace, as

Karimojong territorial sections attempted to recoup their losses from the Great Famine as well as level disparities from the Great Famine and corresponding aid relief (Gray 2000).

Automatic weapons entered Karamoja through a variety of paths. For instance, the GoU has actually provided weapons to various Nilotic groups to establish paramilitary forces in an effort to suppress uprisings or control neighboring groups. Guns also flow across the Sudanese and Kenyan borders where they are quickly sold in open-markets (Narman 2003). The first widespread introduction of AK47s was in 1979, when the Matheniko looted the well-stocked army barracks after Amin's overthrow. Locals took anywhere from 12,000 to 60,000 weapons (Mkutu 2007:36, Stites et al. 2007:55, Wilson 1985). In addition, the Matheniko joined the Turkana against the Bokora and the Pian, a notable alliance, in which a Karimojong territorial section aligned with a former enemy to attack a fellow Karimojong territorial section, thus stoking intratribal violence (Stites et al. 2007:55). Bokora groups did not acquire similar weaponry until 1983, when they ambushed military transports assigned to the area (Akol and Gray 2009, Gray 2000, Okudi 1992, Sundal 2002).

After AK47s became commonplace, violence escalated to a new level. Armed groups had the ability to ambush vehicles traveling along main thoroughfares and were able to launch raids and counter-raids indiscriminately (Gray, Akol, and Sundal 2007). Insecurity has far-reaching effects, particularly during drought years when families seek alternative strategies to support themselves. Women and girls fear

traveling to the bush to collect firewood, wild greens, or medicinal plants because raiders may attack them. In addition, aid agencies have been forced to halt distribution periodically due to the precarious travel conditions on the main roads (Stites et al. 2007:59). The Human Rights Watch (HRW) report, *“Go Get the Gun!” Human Rights Violations by Uganda’s National Army in Law Enforcement Operations in Karamoja Region* (HRW 2007), states that from July 2003 to August 2006 at least 1,000 people died as a result of armed violence, which includes cattle raids, theft, and law enforcement activities in the pursuit of raiders and raided cattle.

Violent Disarmament

Ending cattle raids has been an overarching policy for Karamoja since colonialism. The GoU has undertaken numerous disarmament exercises in Karamoja, which has been inundated with automatic weapons – AK47s and G3s. The current administration, under Yoweri Museveni and the National Resistance Movement (NRM) has implemented several disarmament operations since 1986. First, as a response to armed cattle raids in neighboring agricultural districts, the Ugandan parliament passed a resolution to disarm the pastoralists of Karamoja in 2000. When the Uganda’s Peoples Defence Force (UPDF) was deployed, the GoU estimated that approximately 40,000 to 100,000 weapons would be confiscated from Karamoja (HRW 2007). A team from Tufts University (Stites et al. 2007), which has examined human security in Karamoja, reported that “prior to the start of the disarmament nearly every adult male carried a weapon in public” (ibid: 56). Museveni himself launched the voluntary arms reduction for the Bokora territorial

section. The voluntary phase incorporated “stakeholders and partners,” including Members of Parliament (MPs), local governmental administrators, NGOs, civil society groups, and Karamojong university students. The Karimojong were given incentives, such as ox plows, building materials, and food, in return for their weapons. Negative effects of the incentives were quickly realized. For instance, unarmed households were easily identified by the presence of corrugated steel roofing or plows in their homesteads and became the target of subsequent raids (Stites et al. 2007).

On February 15, 2002, after UPDF soldiers reportedly had collected 10,000 weapons, the GoU replaced the voluntary disarmament program with cordon and search tactics (HRW 2007, Mkutu 2007). Cordon and search is a military tactic in which UPDF soldiers surround an entire homestead and then search the premises for weapons. UPDF soldiers arrive at a homestead in the middle of the night so they can secure the perimeter undetected. At daybreak when the first residents leave their homestead they find UPDF soldiers at all exits. The soldiers assemble all residents either in the cattle pen or outside the homestead before they search each hut individually. As it has been deployed in Karamoja, cordon and search is fraught with problems and documented human rights abuses (HRW 2007). First, having UPDF soldiers enter huts in the absence of the owners allows the soldiers many unobserved opportunities to loot from the huts (Stites et al. 2007). Second, residents of the homesteads are not allowed to leave for any reason until the search is over, which may take hours. During this time they are left to sit outside in the direct sun.

Some even suffer abuse as the soldiers try to find out where any guns are hidden. Third, soldiers use force to restrain, coerce, and punish anyone who resists. Soldiers confiscate any weapon they find and if no weapons are found they take “suspects” (most often men) to the army barracks. Detainees are released when someone turns in a gun on their behalf. During detention suspects may suffer abuse and torture (ibid).

The 2001-2002 disarmament was not evenly administered, and some groups surrendered more weapons than others. For example, the Bokora reportedly suffered the greatest losses (weapons, cattle, and human lives), whereas other sections, like the Matheniko, retained their arms and raided the Bokora without resistance (Gray et al. 2003, Stites et al. 2007, UHRC 2004). This phase of disarmament abruptly ended after the UPDF was reassigned to northern Uganda to combat the Lords Resistance Army and to Uganda’s western border with the Democratic Republic of Congo (HRW 2007). Political divisions in Karamoja escalated and raiding intensified after groups quickly rearmed and sought to restock their animals (Gray, Akol, and Sundal 2007).

In September 2004 disarmament efforts resumed (HRW 2007). As part of an anthropological research team, I was in Moroto District from September to December 2004 and witnessed UPDF soldiers enter Moroto. We spoke to Karimojong directly about disarmament tactics and cattle raiding. A month prior to my arrival raids and road ambushes were occurring at least once a week, but by mid-September the Jie, Bokora, and Matheniko had declared a truce. Our informants

attributed the truce to a looming famine—people needed the freedom to migrate to outside districts as a means of survival—and the pending WFP food distribution (Gray, Akol, and Sundal 2007). The truce went unnoticed by the GoU and by October 2004 disarmament operations resumed. Rather than offer their guns voluntarily and be subject to unopposed raids, as happened for many in 2002, men instead hid with their weapons. UPDF soldiers began cordon and search tactics in December 2004. Our research team entered a homestead immediately following cordon and search and found that several of the men had been taken to the barracks as suspects. After two days relatives submitted two guns for the men's release. We spoke to one of the released men who reported beatings (his bruises were visible) by UPDF soldiers. Stites and colleagues (2007), who were also in Karamoja in 2004, reported that due to locals' mistrust of the government, the disarmament had little to no chance of success. The 2004-2005 disarmament was in fact largely unsuccessful, but it served as a time for mobilization and information gaining, which led to the 2006-2007 operation.

In 2006 the UPDF altered its voluntary disarmament program to one of full-fledge force. The specific goals of the UPDF were to track raided cattle, arrest suspects, and disarm locals, but it did so using violent and destructive means. In direct challenge to the United Nations High Commissioner for Human Rights' report (UNHCR 2006) on the "indiscriminate and excessive use of force by the UPDF....that does not comply with international human rights law and domestic law," Museveni stated that UPDF would continue disarmament *at all costs*. So far these costs have

manifested in the destruction of villages, claims of torture, and counterattacks by Karimojong bandits (HRW 2007).

In May 2006 UPDF soldiers re-entered Kotido District. Twenty-three civilians were killed, 22 injured, 279 arrested, and 639 weapons collected. Attack helicopters, armored vehicles, and tanks entered Karamoja in November 2006; aerial bombings also ensued. Members of the Tufts team (Stites et al. 2007) were again in Karamoja and witnessed the aftermath of UPDF village visits where they saw homesteads smoldering and people injured. "Reports from communities and our mapping of raids indicate that raids often followed in the immediate wake of UPDF disarmament or military operations. For example, Jie raiders attacked the village of Napetet in Moroto district shortly after the UPDF disarmament on 3 June 2006 and stole 218 head of cattle" (Stites et al. 2007:70). The United Nations High Commissioner for Refugees (UNHCR) reported that at least 161 (and up to 189) civilians were killed during cordon and search maneuvers from October 29, 2006 to March 31, 2007 (HRW 2007:29).

I was living in Kampala, Uganda, five months after the start of the 2006 disarmament. While in Kampala I spoke with many Karimojong who fled Moroto as a result of the UPDF disarmament. I saw photographs of the aftermath of one cordon and search maneuver that took place in Moroto District in January 2007. These photos were also shared with Human Rights Watch (2007:44-46) and depicted burnt human skeletons, men severely beaten on their buttocks, and entire homesteads burned down. Human Rights Watch obtained victim and eye-witness

testimony for four cordon and search operations in Kaabong District and three operations in Moroto District.

The pattern described was almost identical: soldiers first rounded up the men outside their manyattas (homesteads) and then subjected them to collective beatings, often accompanied by soldiers' oral commands to "get the gun." According to the victims, soldiers used sticks, whips, guns, and tree branches to carry out the beatings (HRW 2007:50).

Torture ensued following cordon and search. Detained suspects at the barracks suffered "severe beatings and violent interrogations, along with deprivation of food, water, and shelter" (HRW 2007:52).⁹

Impact of Violence

Since the turn of the 19th century, the history of Karamoja has been marked with political instability, environmental disasters, and high human morbidity and mortality. In the current crisis, aid agencies play an important role in population survival and well-being. However, little is known regarding indigenous coping and healing methods, or how these strategies can be strengthened to improve health and initiate conflict resolution. The following chapters address the Karimojong medical system and how it has responded to long-standing armed conflict, environmental degradation, changing cultural lifeways and Western intervention. These chapters specifically examine how insecurity and structural violence have altered Karimojong healing strategies, community well-being, and Karimojong healers' livelihoods.

⁹ I experienced cordon and search first hand when the community I lived in underwent an operation. That morning UPDF troops surrounded our village; one soldier was positioned behind an arms launcher to block the exits to the main road. No one was allowed to leave for several hours until a gun was found at a neighboring village.

Chapter 3 Theoretical Orientation: Medical Anthropology

The histories of both anthropology and medicine show these disciplines to be notable for their lack of attention, respectively, to oppression (and, perhaps, to human suffering in general) and to the sickness of the poor" (Farmer 2001).

Medical anthropology encompasses all anthropological studies of health and healing. Medical anthropology takes the tools of anthropology and applies them to human illness, suffering, disease, and well-being" (Brown et al. 2010:4).

Global processes impact daily experiences at the local level, altering how community decisions and concepts of health and healing are reproduced. To accurately examine health and disease in any setting, one must take a holistic approach, paying particular attention to the historical factors which shaped the current health conditions (Feierman and Janzen 1992). It is thus necessary to study not only Karimojong therapeutic strategies but also their contexts, especially the political and economic factors which have led to rising morbidity rates among the Karimojong today. Medical anthropology, most specifically through its critical lens, enables one to examine the realities of the healthcare system at the local level but also within the context of the global structural processes of domination and inequality that define both healthcare access and therapeutic approaches.

According to Brown et al. (2010:6), although the theoretical orientations within medical anthropology are highly varied, there are four basic premises: (1) the synergy between human biology and culture define human experiences; (2) cultural behaviors as well as the sociopolitical realities influence the distribution of diseases; (3) humans' cultural beliefs and epistemological assumptions bound their

interpretations of the human body and symptoms; and (4) cultural components of healing systems directly impact the effectiveness and societies' views of healthcare systems.

What are Health and Sickness?

From an anthropological perspective, health and sickness are broadly defined phenomena that convey, at the individual or community level, states of physical, psychological, and social well-being. The World Health Organization (WHO 1978:2) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Defining health as "not merely the absence of disease" is an important contribution by the WHO because it allows for cross-cultural understandings and interpretations of what it means to be healthy.

Because disease, illness, and sickness are not interchangeable terms, a brief clarification of how these terms are defined within medical anthropology and how I use them in the present study are required. First, disease is the practitioner's or medical system's explanation of the illness. In medical anthropology, the term illness refers to how the sufferer and her support network perceive and respond to the symptom's expressions; illness "encompasses the human experience and perceptions of alterations in health, as informed by its broader social and cultural dimensions" (Brown et al. 2010:5). While disease is the medical practitioner's classification, illness is the culturally-defined explanation of the patient's symptoms and actions (Janzen 2002). Kleiman (1988:3-5) explains these differences:

Illness refers to how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability....Illness behavior consists of initiating treatment (for example, changing diet and activities, eating special foods, resting, engaging in exercise, taking over-the-counter medications or on-hand prescription drugs) and deciding when to seek care from professionals or alternative practitioners.

Disease, however, is what the practitioner creates in the recasting of illness in terms of theories of disorder....The healer – whether a neurosurgeon or a family doctor, chiropractor or the latest breed of psychotherapist – interprets the health problem within a particular nomenclature and taxonomy, a disease nosology....

Finally, anthropologists use sickness as a term to describe the conceptualizations of both disease and illness. Sickness refers to “all unwanted variations in the physical, social, and psychological dimensions of health” (Brown et al. 2010:5). The term sickness accounts for the embodiment of suffering in which economic, political, and institutional forces influence the expression of illness and disease (Kleinman 1988:6). Thus, when discussing Karimojong descriptions of ill health, I use the term illness; whereas I use the term sickness to describe broader aspects of suffering that include both its biological and social determinants.

During sickness patients and their therapeutic network initiate acts to restore and build health or wholeness. Medical anthropologists look for both the causation and interpretation of sickness and the holistic aspects of healing. “The sickness experience, in whatever cultural setting, and its entry into therapy with the anticipation of healing, is at the heart of the focus of medical anthropology” (Janzen 2002:150). Medical anthropologists use their training and theoretical orientations to

examine healing systems, which incorporate aspects of cultural, political, and social features including religion, medicine, and social structure (Brown et al. 2010).

Healing Systems

Medical systems share a number of features, such as the concept of illness etiology, therapy management, specialization of practitioners, pharmacopeias, and diagnoses of problems and procedures, and can thus be compared (Sindiga 1995). Healthcare itself is a “set of beliefs and social actions which cope with potential and realized dangers that threaten human well-being and survival” (Shelley 1985:3). The current study examines Karimojong ethnomedicine and healthcare, which include both biomedical and indigenous therapeutic strategies. Throughout the dissertation I discuss Karimojong approaches to healthcare as ethnomedicine. This is an inclusive term for all healing systems the Karimojong employ, including both biomedicine and indigenous medicine. I use the terms indigenous medicine or local medicine interchangeably to refer to historic Karimojong approaches to health, healing, and sickness. Finally, I use the term biomedicine to denote all forms of healing based on the Western scientific tradition.

Ethnomedicine is designated as indigenous practices and beliefs regarding health, illness, and healing; it is a medical system of any form (Brown et al. 2010). In fact, “all medical systems constitute ethnomedicines in that they developed from and are embedded in particular sociocultural systems, regardless of whether they are small-scale or state societies” (Singer and Baer 2007:102). Biomedicine is a specific ethnomedical system based theoretically in Western science and ideology that

defines health as the absence of disease (Janzen 2002). Like any other medical system, it is influenced by its sociocultural history, which has shaped its beliefs, practices, and protocols (Gaines and Davis-Floyd 2004). As a therapeutic approach, it focuses on illness symptoms, how to rid the body of disease, and how to bring the individual back to a disease-free state. Biomedicine is itself culturally construed. Alternative terms for biomedicine include allopathic medicine, Western medicine, cosmopolitan medicine, and *bourgeois* medicine; all of which denote biomedicine's ideologies of science and modernity (Gaines and Davis-Floyd 2004, Singer and Baer 2007, Timura 2007). Ethnomedicine thus includes all forms of healing or sickness prevention within a given group, which may include both biomedicine and indigenous medicine.

Nonbiomedical or indigenous systems typically define ill health as a wider set of relationships, focusing on the social and symbolic treatments (Allen 2002:12). Indigenous medicine among African pastoralists differentiates itself from biomedicine in significant ways. First, illness is not viewed as a physical disease, but rather as a consequence of social interactions; physical disorders reflect social disharmony (Sindiga 1995:21). Second, indigenous medicine among African pastoralists problematizes etiology, encompassing both "natural" and "unnatural" factors, and has a strong emphasis on medico-religious healing.

Understandings of Indigenous Medicine

According to the WHO (2002:7), indigenous medicine incorporates a multitude of health ideologies and practices that utilize plant, animal, and mineral-

based medicines as well as spiritual therapies to prevent, diagnose, and treat illness or to maintain well-being. Because indigenous medicine often reflects a population's historic resolutions and ideologies related to health and healing, it is often mislabeled as "traditional medicine." Labeling of indigenous beliefs and practices as "traditional" is problematic for numerous reasons. First, marking local, non-Western medicine with the word "traditional" immediately indicates that indigenous medicine is not modern and is, thus, outdated. The label "traditional" imposes a dichotomy between local (i.e., primitive) medicine and biomedicine (i.e., modern). Second, the word "traditional" implies a stagnant, unchanging belief system, one in which no developments or adaptations have occurred over time. Because indigenous medicine does not fit either of these stereotypes, it should not be labeled as such. In fact, it is "based on indigenous knowledge of a given people, a given community, and their experiences in the context of the local culture and environment—it is dynamic and changes with time depending on the prevailing situation" (Weisheit 2003:1).

Anthropological Studies of Health

Under the rubric of anthropology, health has been studied through multiple methodologies: demographic analyses; examinations of religious systems; human population biology and adaptation; nutritional studies; and the examination of behavioral strategies (such as maternal caretaking methods), among others. In its early stages, medical anthropology was broadly divided among three anthropological "camps": biological, sociocultural, and applied anthropology.

Biological anthropologists examined aspects of health and illness in relation to evolution and adaptation, human growth and development, human reproduction, human nutrition, and human genetic variation. In contrast, sociocultural anthropologists explored the relationship between medical systems and cultural practices and beliefs. Finally, applied anthropologists worked within the public health sector to introduce biomedical health systems to indigenous systems or to improve the quality of care or function of existing biomedical units (Brown et al. 2010, Sobo 2004). Today, however, medical anthropology is a diversified field that includes a broad list of foci: it examines illness treatment and prevention methods as well as communities' access to healthcare; it studies the pattern of diseases in varying environments; it illuminates how access to power influences health and healing methods; it decodes the meanings of signs and symbols relevant to the experience of health through an examination of cultural practices and traditions; and it focuses on the impact of globalization on individual and community health (Janzen 2002). Medical anthropology thus incorporates the variety of theoretical perspectives found within anthropology.

Functionalism

In the mid-1950s, anthropologists used a functionalist approach to explain the healing methods of non-Western societies. Ethnographic descriptions were largely focused on the "other" or "exotic" non-Western societies to determine how cultural features operated as ordered systems that could be analyzed per their operating parts. Medical and cosmological beliefs reflected the larger cultural

system; therefore, medical treatments and healing methods were analyzed in terms of their function in relation to the cultural-specific disease or affliction (Janzen 2002:27). Observations of health, healing, and medical systems were couched in analyses of cosmology and cultural beliefs in which therapeutic rites and rituals were explained as being unscientific and primitive, demonstrating the need for biomedicine.

One of the largest pitfalls of functionalism is that it reduces cultures to a system of working parts absent from their historical roots and influence from individuals within or outside the culture (Barnard 2000:77). Furthermore, the functionalist perspective categorized indigenous medicine as traditional, primitive, and magical, whereas Western biomedicine functioned in a modern, developed, and scientific manner.

Within British anthropology, functionalism arose at the same time as colonialism. Anthropologists, employed by British administrations, attempted to understand the colonized societies; however, their work often excluded analyses of the effects of colonialism on those cultures (Layton 1997:27). Functionalists (Buxton 1973, Evans-Pritchard 1940), described non-Western societies as if war, colonialism, and other international influences did not affect them. For example, Buxton's (1964, 1973) research on the Mandari pastoralists of Sudan classified disease etiology through the function of religion. In the 1950s, the Mandari described sickness as either God-caused or human-induced. The generalized etiology categories failed to address power relations, historical processes such as colonialism and the impact of

Christian evangelization, and the complex interplay of health, illness, and healing notions (Janzen 2002). While Buxton provided detailed descriptions of Mandari cosmology and how Mandari spirits wreaked havoc on human health, she did not investigate the process of Mandari therapeutic decision-making or their utilization of nonindigenous medicine, such as their reliance on pharmaceuticals to inoculate their cattle against Western diseases.

Public Health and Clinical Anthropology

In the 1950s and 1960s medical anthropology was utilized as a means for biomedical domination. "Extraordinary indigenous systems of thought were conceptualized as beliefs to be studied so that biomedicine could be more effectively enrolled in the service of improving people's health" (Saillant and Genest 2007:xxi). Anthropologists continued their work with colonial regimes to determine the barriers to Western health interventions. During colonialism, anthropologists worked in an applied setting in which they investigated indigenous beliefs and political organization to help design ways to implement top-down development schemes, including healthcare programs. "There was, at that time, little critical reflection on the purpose of such programs or on the perceived needs of the populations the programs sought to serve. Studies of traditional healers, including birth attendants, proliferated at this time" (Castro and Farmer 2004:167). As the era of colonialism drew toward an end, some medical anthropologists continued their work in the public health field, acting as cultural brokers to ease development efforts in regard to healthcare (Ferzacca 2004).

Today, medical anthropology contributes to public health in two significant ways. First, applied medical anthropologists who are primarily interested in the improvement of health services may still work as intermediaries between patients and healthcare providers. Anthropologists working in this capacity facilitate the acceptance of biomedicine as well as the shaping of biomedical care that is culturally relevant to its patients. Second, increasing awareness of anthropology's contribution to the cultural context of healthcare influenced many biomedical practitioners to incorporate and apply anthropological training to their clinical work. Anthropologist-physicians (or anthropologist-nurses) utilize their biomedical and anthropological knowledge in the design, improvement, and implementation of international health systems.

Medical Pluralism and Therapeutic Decision-Making

Because indigenous healing methods (currently and historically) have not been isolated from other medical systems, the examination of ethnomedicine must include a holistic perspective. Medical pluralism examines the myriad of healing regimens that make up a society's ethnomedicine and incorporates the examination of health, illness, and all healing strategies (Sindiga 1995). The approach to the study of contemporary healing methods that incorporates the historical development of a society's cosmology and medical systems became prominent in the late 1970s. Medical pluralism allows for the study of change in medical systems, which was not addressed by the functionalist approach. Medical pluralism refers to the array of

medical systems, which are often complex and varied, that inform an ethnomedical system within a society (Baer 2004).

In many medically pluralistic societies, the biomedical perspective is dominant over and may limit the influence of other medical systems (Baer 2004). For example, public health programs rely on a biomedical perspective – they examine well-being as a lack of disease and design health services based on this Western ideology of science (Good 1987). Investigating illness from an ethnomedical perspective, rather than just disease, includes both etiology and the examination of constructed signs and symbols associated with health and illness.

Medical anthropology examines the social context of therapeutic decision-making (Janzen 2002:218). Janzen's (1978) analysis of Kongo therapy management in Lower Zaire advocated a theoretical shift that highlighted medical pluralism. Janzen described how the quest for therapy in Kongo society incorporated indigenous as well as biomedical treatments. Up to this point, many anthropologists still examined medical systems as a dichotomy: populations either adopted biomedicine or they were non-Western societies that only used "traditional" healing. Janzen showed that African healing was affected by imported biomedicine, but biomedicine did not wholly replace indigenous medicine. In fact, the Kongo of Lower Zaire (typical of many African populations) utilized multiple forms of therapeutic methods but relied heavily on their indigenous explanations of health and healing.

Phenomenology and Embodiment

In the 1980s and 1990s medical anthropologists became increasingly focused on the body as a metaphor to examine health and healing (Janzen 2002). A shift occurred “from objectified descriptions of the body in health and illness to subjective, in-depth explications of the body as lived” (Becker 2004:125). This interpretative shift reflected the growing application of phenomenology within the discipline as a whole. Rooted in philosophy, phenomenology evaluates the lifeworld,¹⁰ the lived world that human experience prior to critical reflection and theoretical thought (Becker 2004). Anthropologists have applied phenomenology to examine how humans embody sociocultural forces, ideas, and experiences.

Embodiment has been applied to studies of gender, class, disability, violence, trauma, illness, and healing. According to Merleau-Ponty (1962), embodiment is a state of being defined as the lived body or lived experience. Phenomenology for Merleau-Ponty was “concerned with *description* of the lifeworld, not the scientific or quasi-scientific *explanation* of ordinary experience” (Matthews 2002:32). One important contribution of phenomenology has been the examination of how health, illness, and healing techniques are embodied. Individuals’ (and communities’) historical, political, and social realities shape the meanings and bodily expressions of health and illness experiences. One way to elicit these experiences is through the examination of illness narratives that use the body as a metaphor to explain accounts of violence, trauma, and suffering. Specifically, phenomenology examines how past

¹⁰ Husserl, an early phenomenologist, coined the term *lebenswelt*, lifeworld, to explain “the historically achieved structure of beliefs and values that make up the taken-for-granted everyday world in which we all live” (Edgar and Sedgwick 2002:110).

experiences are reflected in the reality of the present; thus, suffering acts of violence becomes embodied memory that shapes the individual's perception of the experiences of varying states of well-being and what it means to be healthy or ill. The embodied human experience explains how the body processes cultural meanings and functions as a link between the natural, spiritual, and cultural worlds (Singer and Baer 2007).

According to Scheper-Hughes and Lock (1987:31), an examination of "the interaction among the mind/body and the individual, social, and body politic in the production and expression of health and illness" is essential. They used the construct of the mindful body to examine three levels of embodiment: the manner in which the individual body experiences sickness and health or the phenomenological reality of body-self; symbols and structures which represent the social body; and the political body that regulates and controls individual and collective bodies (ibid). The mindful body metaphor, or the bio-psycho-social approach (Brown et al. 2010:11), was a challenge to the dominant thinking which relied too heavily on a biomedical approach that examined sickness by separating the disease (the body) from the illness (the mind). By examining the mindful body the sufferer experience is addressed. "In medical anthropology, sufferer experience is understood as a social product rather than a completely unique and individual occurrence (Singer and Baer 2007:91).

Scheper-Hughes (1992, 2001, 2008) utilized the mindful body concept to expose the cost of long-term human suffering in a Brazilian shantytown. In her

assessment of maternal detachment and maternal indifference when confronted with child mortality, she discussed the phenomenon of social death or death by suggestion (Scheper-Hughes 1992:385). Scheper-Hughes explained the mothers' seemingly "unloving" character as the embodied experience of the shantytown's economic collapse following the demise of the sugar plantation economy. Shantytown mothers immediately labeled their children at birth as either "fighters" worth investing in or "angels" destined to die. Babies who exhibited signs of chronic hunger were not worth mothers' investment and, as such, were designated as already "dead." These children were the embodiment of a failed political and economic system and were the representation of *luta*, the struggle between the weak and the weaker. In the social body, sickness was also a metaphor for inequality and poverty and manifested itself as illness in individual bodies. Babies experienced sickness, and shantytown mothers, who were themselves economically and nutritionally weak, interpreted these signs of chronic hunger to mean children who were destined to die. Furthermore, child deaths became normalized as being part of the everyday violence in which these residents lived, acculturating future mothers to the fact of ill children, many of whom will succumb to death.

No tears were wasted at an infant burial, often left in the hands of older children. Children buried children on the Alto do Cruzeiro. This practice killed two birds with one stone: it allowed mothers to absent themselves from the burial rites, and it forced children to face and accept death of their siblings as a commonplace and unremarkable fact of life (Scheper-Hughes 2008:29).

Finally, it was the body politic – the lack of infrastructure, economic opportunities, and health resources as a result of historical structures that set in place

the oppression and exploitation of shantytown families. “Large-scale social forces become embodied as sickness, suffering, and degradation” (Farmer 2003:19). Thus, examining the body politic reveals the forces behind the constraining structures leading to ill health and is a key component of Critical Medical Anthropology (CMA).

Political Economy and Critical Medical Anthropology (CMA)

Political economy and critical theory use a Marxist lens when examining health, illness, and healing. For Marxist anthropologists, illness is a direct outcome of the capitalist structure in which the privilege of power and class impacts individual and community access to resources, including healthcare. Critical phenomenology examines “how macrolevel processes of power and political economy are experienced at the microlevel by the individuals and communities they affect” (Brown et al. 2010:12). Influenced by the Marxist approach and phenomenology, CMA examines how broader political and economic processes shape health and well-being through the allocation of health resources and services (Janzen 2002). Furthermore, CMA examines how these processes restrict choice, decision-making, and social behavior as well as mold health, illness, and well-being. This tenet of CMA is also referred to as the political economy of health or political economy in medical anthropology (PEMA). CMA examines the barriers to complete physical, mental, and social well-being, which include “social inequality, class, gender, racial, and other discrimination, poverty, structural violence, social trauma, relative deprivation, being forced to live or work in a toxic physical environment,

and related factors” (Singer 2004:26). CMA strives to understand health in relation to the political economy as well as the biological and social causes of sickness.

One focus of CMA is the medicalization of health and suffering.

Medicalization is the process in which biomedicine classifies life circumstances (including poverty and social distress) as disease, therefore omitting or ignoring underlying social causes (Winkelman 2009:297). According to Singer and Baer (1995:65), “CMA’s understanding of health issues begins with analysis of the impact of political and economic forces that pattern human relationships, shape social behaviors, condition collective experiences, re-order local ecologies, and generate cultural meanings, including forces of institutional, national, and global scale.”

Furthermore, critical medical anthropologists examine health issues to highlight the importance of social justice and to eliminate large-scale health disparities. Farmer (2001, 2003, 2004) proposed that medical anthropologists are obligated to uncover how inequalities are systematically enforced and recreated, resulting in adverse outcomes such as illness, suffering, subjugation, and death. Farmer (2004:315) argued that it is necessary to “understand how structural violence comes to harvest its victims.” Farmer’s work linked the emergence of two infectious diseases – HIV/AIDS and tuberculosis (TB) – to global politics. For example, in the United States TB disproportionately affects more people living in prisons and homeless shelters because these locales are both overcrowded and lack adequate social services. Not only do poverty and discrimination make the poor more likely to live in those locales where TB may be transmitted, but the poor are also more

likely to have weakened immunity, increasing their risk of developing active TB, and are less likely to have the resources for proper diagnosis and access to treatment of TB. Farmer's analysis of TB clearly demonstrates that this disease is not solely a biological phenomenon but is influenced by social factors and structural violence.

Medical anthropologists must go beyond cultural explanations of illnesses to understand how diseases are "historically given and economically driven" (Farmer 2004:317). By examining power relations (Bourgois 1995), CMA uncovers the causes and effects of structural violence—"violence of poverty, hunger, social exclusion, and humiliation" (Scheper-Hughes and Bourgois 2004)—which are often hidden by the hegemony of the powerful. Thus, CMA enables scholars to analyze the effects of structural violence on individual and community well-being. As a theoretical framework, CMA guides researchers to not only examine current health conditions, but to investigate the historical processes which have shaped those conditions, paying particular attention to the impact of globalization and unequal power relations. To understand how these processes come into play and to investigate their devastating and entrenched impact on illness and health, medical anthropologists often rely on ethnography and their immersion in the social space of the group under study to gain access to health and healing behaviors, ideologies, and methods. "[E]thnography offers keen insights about health and behavior that are not easily acquired through other means" (Singer and Baer 2007:52).

Chapter 4 Ethnographic Field Methods

Ethnography is a scientific approach to discovering and investigating social and cultural patterns and meaning in communities, institutions, and other social settings (Schensul, Schensul, and LeCompte 1999:1).

Fieldnotes provide scientific data to the extent that they contain intersubjectively reliable descriptions of beliefs and behavior of individuals in other cultures; and they are humanistic documents to the extent that they enhance our understanding of behavior and beliefs by illuminating their meaning within a cultural context of related meanings (Johnson and Johnson 1990:161).

Introduction to the Field

Ethnographic field research is the examination of people or groups in their everyday settings. Ethnographers immerse themselves in the culture while systematically observing behavior and recording information (Emerson, Fretz, and Shaw 1995). Participant observation is “a process of learning through exposure to or involvement in the day-to-day or routine activities of participants in the research settings” (Schensul, Schensul, and LeCompte 1999:91). According to Schensul and colleagues (ibid), participant observation is a cornerstone in ethnographic research because it confirms social patterns, such as etiquette and norms, over time; normalizes the researcher’s presence in the community; gives cultural data through experiences; and enables researchers to both intuitively and intellectually analyze information obtained. Although participant observation is generally accepted as the leading field method in cultural anthropology, I adopted the approach described by Dewalt and colleagues (1998:259) in which participant observation is just one of many data collection strategies used in ethnographic research. A mixed-method strategy, one that includes both qualitative and quantitative observations, provides a

more holistic picture than either methodology used exclusively (Bernard 2002). In this study, the mixed-method strategy involved daily fieldnotes, open-ended individual interviews, participation in community events, observation of healing activities and caretaking behaviors, and collection of archival data.

This study examines the historical, political, and environmental processes that have shaped current health and healing trends among the Karimojong and investigates an area of Karimojong health that has not yet been examined. No documentation of Karimojong ethnomedicine exists, nor do we fully understand how the emergence of biomedical care has affected Karimojong therapeutic methods. This study incorporates a historical analysis of the Karamoja health sector, observational data of practiced healing strategies, Karimojong notions of health and illness obtained through one-on-one interviews, and an examination of available biomedical programs. Unfortunately, international aid and healthcare initiatives in Karamoja are based on the Western biomedical perspective in which health is defined as an absence of disease. This does not address the Karimojong notions of well-being or social causes of their ill health. Unless the Karimojong perspective is utilized for development initiatives, including healthcare, existing biomedical programs will not accomplish their goal of decreasing morbidity and mortality in the region.

First, this dissertation documents the strategy for survival Karimojong mothers employ for themselves, their children, and their community. Second, it examines the interactions between medical systems available to the Karimojong with

a specific focus on how biomedicine has influenced Karimojong ethnomedicine. Third, it presents a descriptive analysis of Karimojong ethnomedicine, emphasizing indigenous practices and beliefs related to child health and therapeutic strategies. Fourth, it chronicles the work of Karimojong healers including their path to healing, community importance, and medical expertise. And finally, this dissertation documents the effects of poverty and structural violence on Karimojong well-being and available healing methods.

Activities in Kampala

From October 2006 to the end of January 2007 I lived in Kampala District where I took intensive NgaKarimojong language courses and conducted archival research. I was affiliated with the Makerere Institute of Social Research (MISR), which provided access to their library at Makerere University's main campus in Kampala; mediated my research approval through the Ugandan National Council for Science and Technology;¹¹ and provided a research vehicle.¹²

My time in Kampala laid the roots for the ethnographic research and the NgaKarimojong training proved instrumental for the fieldwork's success. For instance, the language instructors tailored all lessons and coursework to my specific research topic. During this time I also created my interview questionnaires (Appendix A) which underwent translation and back-translation (Bernard 2002): I translated all questions from English to NgaKarimojong during the Kampala

¹¹ My research was officially approved by the UNCST (#ss1913) as well as the Human Subjects Committee Lawrence Campus (HSCL #15555) and Moroto District's Resident District Commissioner (RDC).

¹² Dr. Sandra Gray donated this vehicle to MISR upon completion of a 2004 research project in Karamoja. For the current project MISR allowed me to use the Land Rover free of charge.

language course; and then my research assistant and her daughter (both native Karimojong) back-translated the questions from NgaKarimojong to English to ensure the accuracy of the questions' intent.

While in Kampala, I began preliminary fieldwork among Karimojong migrants living in the Kisenyi Parishes of Kampala District. These migrants subsisted mostly through begging (or sending their children to beg) on the busy streets of Kampala. Data obtained from interviews among these migrants are outside of the scope of this dissertation and are addressed elsewhere (Sundal 2007, Unpublished manuscript-a, b). I also attended two Kampala-based events that promoted public awareness of Karimojong culture. The first, *Inaugural Pastoral Week: Untapped Pastoral Potential*, was a two-day conference that brought together academics, aid organizations, and governmental agencies involved with pastoralist groups in Uganda. The second event, *Karamoja Day Out*, was organized by the Karamoja Cultural Trust as the third annual celebratory day for all Karamojong. This event began with a march from the Constitutional Square through the city center and culminated in a celebratory dinner and dance at a local hotel. Attendees included Karimojong MPs, university students, and aid workers, as well as the migrant Karimojong who lived temporarily in the city and worked primarily as street beggars.

Living and Working in Moroto

Moroto District is approximately 12 hours by bus or car from Kampala under precarious travel conditions. The asphalt roads in the northeast region were built

during the colonial era and have seen little maintenance since. Near Moroto, marrum roads replace tarmac; radiating out from Moroto dirt roads.¹³ Many of these roads are impassible during the wet season. Vehicle ambushes (some with fatalities) were also on the rise throughout Karamoja during 2007 and caused many Ugandans and foreigners to avoid this region altogether. In fact, during my tenure in Moroto, World Food Program (WFP) convoys were the targets of many attacks. In May 2007 armed “warriors” waylaid four WFP trucks and killed one driver. In response to this murder, WFP temporarily halted its food distribution, which targeted nearly 500,000 people affected by the ongoing drought (Reuters 2007, WFP 2007).

Due to the dangerous travel conditions, some NGOs in Moroto hire guards armed with AK47s to escort their vehicle along the main transportation routes to curtail attacks. I chose not to hire guards because they would have interfered with my ability to establish rapport within the villages and with the collection of potentially sensitive information (e.g., the role Karimojong healers play in blessing impending armed cattle raids). Furthermore, the UPDF was in the process of a disarmament operation, which was enforced by a large and heavily armed military presence. I feared that if I employed armed guards this would give rise to rumors that my research was linked to the government or the army. Because of the poor road conditions and because I wanted someone skilled in defensive driving to evade

¹³ In Moroto Town there is one section of tarmac, but this too has suffered neglect.

the ever-present danger of an ambush, I employed a Karimojong man to work as both my driver and part-time mechanic.

I also employed Helen Akol, a Karimojong woman, as a research assistant. I had previously worked with Akol during a 2004 study in which I assisted Sandra Gray in a biobehavioral study of maternal strategies and child health (Gray, Akol, and Sundal 2007, 2008, 2009a, b, Sundal 2006). Akol served as a guide, translator, and friend, and provided research support as well as part-time housing.

Moroto District is divided into Bokora and Matheniko Counties. Each administrative county is further subdivided into subcounties, parishes, villages, and homesteads. In Moroto there are ten subcounties (six in Bokora and four in Matheniko). Each subcounty has its own administrative headquarters and biomedical health facility. I focused my research in two subcounties; Lopeei subcounty in Bokora County and Rupa subcounty in Matheniko County (Figure 4.1). I did not randomly choose either of the subcounties, but instead used purposive sampling methods, which can be useful for intensive studies (Bernard 2002). I wished to expand the database of Karimojong communities; therefore, I did not sample the same villages that I had worked in for my primary field sites in 2004.

Because the fieldwork extended across both the dry and wet seasons, I spent a portion of each season in both counties. This strategy proved useful as the road conditions became nearly impassible at the height of the rainy season; nonetheless, I was able to conduct research and interviews in all communities (albeit I had to adjust my sampling methods due to the rain as discussed in more detail below). I

worked for a total of 12 nonconsecutive weeks in Bokora and 10 nonconsecutive weeks in Matheniko. I lived in Bokora for seven weeks and then moved to Matheniko for six weeks. Next, I repeated the cycle and spent five weeks in Bokora and four in Matheniko.

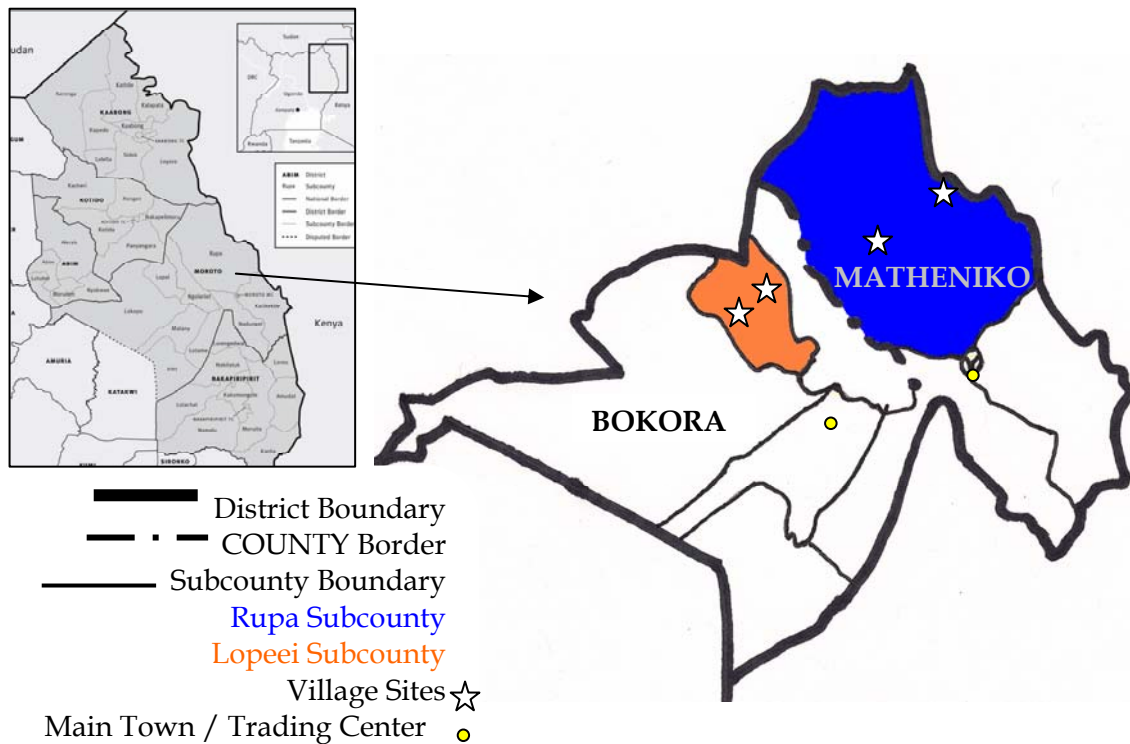


Figure 4.1 Map of Moroto District and Research Sites

I chose not to live in the informants' villages due to safety issues. Cattle raids usually occur at night and the insecurity at each village sampled was too high. In addition, my presence at the villages would have garnered unneeded attention (i.e., armed robbery) to hosting villages. Therefore, I lived at the main town or trading center and commuted daily to the research communities. In Bokora County I lived in Akol's compound, which consists of two mud and thatch huts, a two-room brick

building, and a pit latrine, all enclosed within an outer fence. Her compound is located at the edge of Matany trading center, which is home to many people employed by St. Kizito Hospital and the Verona Fathers missionary. Locals consider this area to be relatively safe; however, there were numerous armed robberies of homes and shops while I lived in Bokora. Akol explained that these acts were on the rise in the past two years. In Bokora, I had plenty of household help; I employed Akol's adult daughter as a general household manager in charge of preparing meals, shopping, and laundry. In contrast, in Matheniko I was self-sufficient and lived alone in a rented room at the old hotel at the base of Mount Moroto.¹⁴

Sampling Frame

I selected villages for inclusion in the study based on two major requirements. First, I chose rural villages to examine the influence of biomedicine on Karimojong ethnomedicine and to document indigenous healing strategies in communities for which accessing biomedicine was to be difficult (due to the rural locale). My second requirement was solely logistical: while there were certainly villages in both Lopeei and Rupa that were farther away from their subcounties' biomedical health facilities I could not reliably access them due to the danger of raids and ambushes and the military presence in extremely rural areas. Furthermore, very distant villages could not be reached due to inaccessible traveling routes.

I obtained a list of villages that fulfilled my criteria from the corresponding subcounty headquarters. At the headquarters I spoke to the subcounty chiefs and

¹⁴ Akol lived at her children's residence during our time in Matheniko County. It was not feasible for me to live with her at this location because it was in the center of town near several drinking establishments and Akol deemed it too unsafe a residence for me.

members of the local council (LC), elected village representatives, who advised me on possible villages, contact persons, and transportation routes.¹⁵ From the lists provided I chose two villages in Lopeei and two villages in Rupa that met my criteria. During my first visit to each village, I gathered as many adults as possible (at the four villages respectively) to explain the research, including information about myself and my research assistant, the project's purpose, how I would protect informants' identities, and my role as an independent researcher. During my second visit to each village, I brought appreciation gifts for the community – tobacco (snuff) and local sorghum beer – both of which are important in Karimojong customs and rituals. I used these appreciation gifts as a way to thank the entire village for allowing me to work there and as a measure to mitigate jealousies that might arise if the larger community perceived me as an extra provider (either financially or with goods) to the informants.¹⁶ During both the first and second village visits informants volunteered for inclusion in the study.

Informants

The broad foci of this research include both the examination of maternal decision-making in regard to child health, as well as the documentation of Karimojong ethnomedicine, including both biomedical as well as indigenous healing strategies. To accomplish these goals, I interviewed and observed two sets of

¹⁵ In Bokora I attended the LC meeting at the Lopeei headquarters and formally introduced myself and research in NgaKarimojong – an act that I believe gave me great credibility because few foreigners speak this language.

¹⁶ I also provided thank-you gifts to each participant at the end of the field season. These gifts consisted of multipurpose bar soap, a clothing item, and one other requested small item, such as a plastic basin, water pitcher, or the monetary equivalent.

informants – Karimojong mothers and healers. My sampling of informants was both purposive and quota-based (Bernard 2002). Overall, I conducted 47 individual interviews: 19 Karimojong mothers, 21 healing specialists, and 7 women who were included in both samples. These seven women originally volunteered to be part of the mothers' sample, but during the course of our interviews they revealed they were practicing healers, and I interviewed them regarding their healing work as well. Table 4.1 provides a list of informants interviewed. When referring to informants in the dissertation, I either use a pseudonym or use the following coding system: two letters indicate the informants' village (AP, MP, AD, or KK); a number corresponds to her hut on the homestead map; and then the date of the interview. For example, KK8 3/21/07 is the code for the woman living in compound number 8 in village KK interviewed on March 21, 2007. There are a few exceptions to this nomenclature. First, I coded male informants with an additional "M" (e.g., AP1M). Second, healers who were not from the four main villages are given a different alphabetical code (MTC, MT, and LT), which refers to the location where they were interviewed.

Criteria for inclusion in the study were relaxed to allow a broad range of informants' perspectives. Nevertheless, I restricted the mothers' sample to those women with at least one nursing child to examine maternal therapeutic decision-making for one of the most vulnerable age-groups (morbidity and mortality in infancy are highest). Three of the women in the mothers' sample did not have a nursing child, however: one was breastfeeding her grandchild because the child's

mother had died soon after giving birth; the second woman had only one living daughter who was over five years of age (all her other children had died); and the third was also caretaking but not nursing her granddaughter because the child's mother was out of the district doing casual labor. I included them in the mothers' sample because the information regarding their lack of a nursing child was not brought to my attention only after several visits and I did not want to appear to have "kicked them out" of the sample.¹⁷ Ultimately each of these women contributed greatly to the sample: two of the women, AP142 and MP6, were also healers; and the third, KK139 (the mother with only one living child), spoke in detail about her caretaking and healthcare decision-making for her deceased children. The criteria for the healers' sample were also loosely constructed; these informants had to be active, working healers whose specializations and therapeutic work fell within the Karimojong folk taxonomy of indigenous healers (discussed in Chapter 7). These informants self-volunteered midway through the fieldwork after I had established some rapport in each community.

¹⁷ This could have caused tension in the homesteads because others may have misinterpreted my actions as not thinking they were "good" informants or that they had done something to offend me.

Table 4.1 Informant List

<i>Mothers</i>		<i>Healers</i>	
ID #	County	ID #	County
AP8	Bokora	AP1M	Bokora
AP22	Bokora	AP2M	Bokora
AP92	Bokora	AP15	Bokora
AP98	Bokora	AP50	Bokora
AP154	Bokora	AP149	Bokora
KK8	Bokora	KK3M	Bokora
KK48	Bokora	KK128	Bokora
KK161	Bokora	KK141	Bokora
KK167	Bokora	KK178	Bokora
MP40	Matheniko	MTC	Bokora
MP43	Matheniko	MP4M	Matheniko
MP45	Matheniko	MP36	Matheniko
MP53	Matheniko	MP68	Matheniko
MP67	Matheniko	MP73	Matheniko
AD3	Matheniko	AD214	Matheniko
AD73	Matheniko	LT5M	Matheniko
AD78	Matheniko	LT2	Matheniko
AD113	Matheniko	MT6M	Matheniko
AD120	Matheniko	MT7M	Matheniko
<i>Combined Sample</i>		MT2	Matheniko
		MT4	Matheniko
AP41	Bokora		
AP43	Bokora		
AP142	Bokora		
KK99	Bokora		
KK139	Bokora		
MP6	Matheniko		
AD155	Matheniko		

Village Characteristics

To understand homestead relationships, in particular healing networks and familial relations, I mapped all homesteads in the four villages (Appendix B).

Mapping provided an overview of each homestead in its entirety and illuminated differences among and within research sites in wealth, security, and environmental features because it gave me the opportunity to view every household in each homestead. Akol and I walked to every household in the homesteads, spoke directly to household members, and collected the full names of each household head (adult women head households) and their husbands. Gathering the complete set of names enabled me to locate co-wives and map familial relationships (e.g., informants' parents, aunts, siblings) reported during interviews. Every circle with numbers on the maps corresponds to an individual household unit; however, the maps underrepresent reproductive women. I only included homes for women who had independent gardens as this indicated that the women were the head of the domestic unit and were likely to be the children's primary caretakers. Adult reproductive women who still worked their mothers' gardens tended to be young, lived within their mothers' compounds, but had constructed their own sleeping hut to receive their husbands to whom they were not officially married. These women are still heavily dependent on their own mothers for assistance with caretaking and therapeutic decision-making.

Bokora Communities

Village AP is located in Lopeei subcounty. The vegetation surrounding AP was of moderate density with numerous Acacia trees growing along a small river within walking distance. Mothers report that AP is a two-hour walk from the Lopeei health dispensary and that it takes them at least three to five hours to walk to the

Matany trading center where the sole county hospital (St. Kizito) is located. A smaller trading center with only three shops is approximately a 15-minute walk from village AP. Opposite this trading center is a large primary school that offers supplemental feeding for students (when food is available). WFP provides porridge in the morning and one meal a day of beans and *atap* (a thick porridge made from sorghum or maize flour) for all attending schoolchildren as part of the incentive to promote education, especially for girls, because the majority of Karimojong children do not attend school.

AP actually consists of two villages; a smaller village, NM, relocated to AP after a devastating 2005 cattle raid in which numerous livestock were stolen and people killed. Village AP is divided into five homesteads (Appendix B): three are enclosed within one exterior fence and the remaining two (one of which is NM) are also clustered together. When village NM joined AP it kept its own, distinct village name, although its residents lived within AP's outer (protective) fence. Homesteads grouped together are a direct result of violence in the area – homesteads which were once independent united for additional protection against potential raids. In the past, homesteads were independent units grouped near each other in a general locale, but not protected by an enclosed fence.

During my sojourn, AP suffered two more cattle raids in which enemies stole livestock and shot residents. The morning after the second raid, I saw the devastation firsthand: a young man was shot in his right upper thigh and was lying under a tree at the periphery of the village waiting for a bicycle to transport him to

St. Kizito hospital (at least a 30-minute ride by car). After the second attack, residents at AP became more serious in their efforts to maintain well-built outer fence and began housing their livestock at nearby army barracks.

At AP I mapped 202 independent households and interviewed 13 individuals: eight women who participated in the mothers' sample and five healers. I divided the mothers among four homesteads so that I interviewed two women from each; I did not interview any women from the small adjoining village (NM).

Village KK is also in Lopeei subcounty and is approximately a 45-minute drive from AP. Over the course of the research, I discovered many familial relationships and connections between these two villages. This underscores the importance of cattle kin, territorial affiliations, and clans among Karimojong communities. Village KK was the largest village I worked in; therefore, I narrowed my focus to only those homesteads represented by one elected local chairman (LC). This LC oversaw three homesteads that were joined together in one enclosed outer fence. Here I mapped 195 households (Appendix B) and interviewed two mothers from each homestead (six women total) and four healers. Informants reported that KK is located a one- or two-hour walk to the Lopeei health dispensary and approximately a six-hour walk (28 kilometers) to Matany trading center. Because KK is located near the border of another Bokora subcounty, KK mothers also reported that they often traveled to the adjacent subcounty's trading center and biomedical facility because it was a shorter walk for them than traveling to either Matany or to the Lopeei dispensary.

Finally, I interviewed one healer who lived in a semi-urban village on the outskirts of Matany trading center.

Matheniko Communities

I was able to reach one remote village at the edge of Rupa subcounty, village MP. Village MP was comprised of six independent, small homesteads spread across the base and side of Mount Moroto (Appendix B). I registered 99 households, interviewed six mothers and four healers. MP is unique in my sample in that its location is near the Tepes, a neighboring ethnic group that resides on the mountain. Informants from other Matheniko villages labeled village MP as a Tepes community although MP residents self-identified as Matheniko Karimojong. Although informants from village MP reported amicable relations with Matheniko on the lower plains, one informant (MP36) expressed her concern that lower plains Matheniko might accidentally believe she was Tepes if they saw her ascend from the mountain. This fear is warranted as relations between Tepes and Matheniko are hostile. Numerous MP informants attested to this fact as they repeatedly described the ongoing raids their village had received from Tepes warriors. Thus, village MP was in a particularly precarious location and subject to attacks from both Matheniko below and Tepes from higher up on the mountain.

The terrain near MP was unique due to its location on the mountain. Vegetation was thick and lush even in the dry season, with little grass. The dense brush prompted women to cultivate gardens (and sometimes to build temporary housing) on the top of the mountain in addition to their terraced garden plots on the

mountain's side. Village MP is nine kilometers from the Rupa health center and a four-to-five-hour walk from Moroto Town.

The fourth location, village AD, was on the plains in Matheniko County and is the nearest village in my sample to its corresponding health center. Mothers reported it took them less than one hour to walk to the dispensary and only a few hours to walk to Moroto town. I was unable to travel to any village past AD due to deep gullies and several dilapidated bridges on the access road. I did not interview women from every homestead at this village due to its large size. I choose to work in six homesteads only, about a third of the entire village, which were all under the domain of one LC. In these six homesteads (Appendix B), I recorded 220 households and interviewed six women (one from each homestead) and one healer. As the rainy season progressed this village became inaccessible by vehicle: the road from Moroto Town to AD crossed three rivers and contained impassible black soil. Therefore, my research was abbreviated by the rainy season in this village. Because I interviewed all women informants first at each homestead and then began interviews with healers, my sample of healers at AD only includes one individual.

To compensate for the smaller sample size of Matheniko healers I interviewed healers living in accessible villages or within Moroto Town. On days when there was too much rain to drive to MP or AD, I chose alternative villages or worked in town instead. First, I frequented a Matheniko community (village LT) with which I had prior contacts from the 2004 study and which was also located in Rupa subcounty. I was already known there, which expedited the introductory

phase and enabled me to speak to two healers with relative ease. At the primary villages (AP, KK, MP, and AD) I spent months gaining villagers' trust while I conducted interviews with the mothers before attempting interviews with healers, who at times are reserved lest they divulge "trade secrets."

Lastly, I interviewed four healers in Moroto Town (MT). Two of the interviewees came to my research assistant's lodge for the interview and for the remaining two we went to their respective homes. One of these healers was actually a patient at Moroto Hospital. I met him on the hospital grounds, took him to the lodge for the interview, and drove him back to the hospital after we completed the interview.

Semi-Structured Interviews

For each set of informants I followed a semi-structured interview format (Appendix A). Semi-structured interviews include open-ended questions about a range of topics grouped accordingly (Bernard 2002:203). I spoke both English and NgaKarimojong during all interviews and Akol translated for me when needed. The mothers' interviews occurred over the course of two semi-structured interview sessions, each lasting between two and six hours, whereas the healers' interviews typically lasted four or more hours in one session. I randomly choose which informant to work with each day in an effort not to disrupt their typical work patterns. All informants were told to continue any planned activities they had for the day, which enabled me to observe their work and caretaking behavior. However, most interviews usually occurred within the informants' sleeping hut or

day shelter where informants would intermittently answer questions, narrate events, receive visitors, prepare meals, or tend to children.

All questionnaires (for both the mothers' and healers' sample) elicited general demographic data: informant's name; age or date of birth; marriage details including husbands' and co-wives' identifying information; and informants' and husbands' work activities. The demographic section also focused on women's reproductive histories to gather data regarding the outcomes of each pregnancy, child birth, and child death. I used open-ended questions to elicit narrative-style responses when mothers spoke of previous trauma. For instance, I asked mothers to discuss their impressions and opinion of healthcare service provided at varying biomedical health facilities. Mothers would typically provide their impression (the care was good or bad) and then told a story that exemplified why they felt this way (e.g., what happened to give them have this impression). This method also elicited detailed information on therapeutic strategies mothers used to counter life-threatening illnesses as well those illnesses that ultimately ended in child deaths.

For the mothers, the second section of the questionnaire dealt with biomedical healing strategies. Mothers were asked to describe each biomedical health facility they utilized, including distance traveled to each, services provided, cost of care (including both set fees and accrued fees such as "tips" paid to nurses to ensure good care), staff (number and rank of personnel), operating hours, and quality of care provided. In addition, mothers explained the circumstances and outcomes of their last trip to each health facility. Finally, mothers described their

experiences and general impression of the medical staff and services, then offered suggestions for improvements.

During the second interview session with maternal informants, I switched the focus from biomedical care to indigenous healing techniques. To begin, mothers listed their own classification (or folk taxonomy) of the types of Karimojong healers. I used the technique of taxonomic elicitation outlined in Bernard (2002) and Weller (1998:372): I asked informants to identify, name, and describe healer classifications through questions such as “What kinds of Karimojong healers are there?” and “What type of work does each type of healer perform?” Mothers named the healer category and described the type of work each did and type of healing instruments used. I then asked mothers what type of indigenous healers they relied the most on, what services they provided, the cost of treatments, and the quality of care provided. Mothers described the circumstances and outcome of their last visit to a healer in detail. Next, I asked mothers to explain their home healing techniques – activities and methods they employed before seeking additional care as well as in conjunction with other healing strategies. Finally, I asked a series of questions pertaining to how mothers determined which type of healthcare to utilize, when and why they used multiple forms of healthcare, and how biomedicine and indigenous medicine compared as healthcare strategies.

Interviews with healers began in a fashion similar to the mothers’ sample. I collected general demographic and reproductive histories and elicited the taxonomy of Karimojong healer types. Next, healers recalled how they became a healer: age

when their healing capabilities were noticed; events that indicated they had healing abilities; responses from their communities, including the details regarding suppression and initiation rituals; and their induction as a working healer. The final series of questions related to how biomedicine altered or influenced their indigenous healing knowledge and techniques. In addition I collected information pertaining to rites and illness episodes they endured. When healers were willing, I asked them to list all medicinal plants they knew and utilized, including their local names, preparations, and curative qualities. Not all healers were willing to provide detailed information regarding medicinal plants because they did not want their personal cures to become general knowledge or they were not herbalists.

I also attended local rituals, ceremonies, community meetings, and healing sessions in which I collected observational data and conducted unstructured interviews. Finally, I updated a Karimojong local event calendar originally developed by Akol and Gray (2009) (Appendix C).

Moroto District Biomedical Data

I spoke directly to the district medical officer and the medical records clerk in Moroto Town, who granted me permission to copy reports from Moroto's health centers. I copied monthly records for Moroto District as a whole, subtotals for Bokora and Matheniko Counties, and monthly records for Lopeei and Rupa subcounty health centers. These reports tallied out-patient attendance, out-patient diagnosis, and immunization. The out-patient diagnosis included 61 categories divided into communicable and noncommunicable diseases and maternal and

perinatal conditions. I use these archival biomedical data as a supplement to information obtained through direct interviews and observations. Archival data offer strong complementary information, but have limitations because data collection methods are largely unknown (Bernard 2002).

In Bokora County I visited my informants' subcounty health center and St. Kizito Hospital in Matany trading center. I spoke to staff at both locations, toured the facilities, and either visited patients at or went with patients to both health facilities. I also attended one of the general immunization days at Matany hospital with Akol's daughter and granddaughter. In Matheniko County I visited the Rupa subcounty health center. I frequented this locale the most: I toured the facility and spoke directly to the head nurse; I visited this health center when one of my informants traveled there to attend the infant immunization clinic and food distribution center; and I gave rides to this health center to several of my informants' family members or other villagers. I also toured Moroto Hospital and visited informants in Moroto's wards.

Finally, I spoke with biomedical professionals based in Moroto District regarding the incorporation of indigenous healing methods into the broader healthcare program. One veterinarian has worked in conjunction with Karimojong healers to establish and market Karimojong herbal remedies. In addition, a doctor and nurse stationed at Moroto Hospital contacted me about working with Karimojong healers.

Data Analysis

I recorded all data (through interviews, participant observation, and archival data) in a collection of notebooks. I kept daily fieldnotes of both observational data as well as interview responses which I entered as the events and interviews occurred. I also digitally recorded all interviews. I typed all interviews and observations into Word documents at the end of the field season rather than during my time in Moroto District and listened to the recorded interviews during transcription. I used text analysis to examine qualitative data through the coding and memoing of fieldnotes (Emerson, Fretz, and Shaw 1995:143) as a systematic method of analysis.

For my analyses, I uploaded all transcribed Word documents into the ATLAS.ti software program. ATLAS.ti facilitates qualitative analysis of textual (as well as graphic, audio, and video) data and is based on grounded theory methodology in which codes are pulled from textual data, organized into categories, and are then the basis for theories (Bernard 2002:488, Bernard and Ryan 1998:609). I analyzed my data through a two-phased coding system (Emerson, Fretz, and Shaw 1995). First, I examined the fieldnotes (the text) line-by-line and developed general themes of interest (first set of codes, e.g., “healer suppression ritual”). Then I sorted all of my fieldnotes according to the themes. Next, during focused-coding I examined each set of themes and constructed new, detailed variables of analysis (second set of codes, e.g., “age at suppression” or “food served at suppression ritual”). I found this method to be a systematic way to develop thematic narratives

used to qualify Karimojong perspectives of well-being, healing, and survival strategies and to generate both qualitative and quantitative data. I Used ATLAS.ti to compile documents of aggregated text for each focused code.

Chapter 5: The Rise of Biomedicine in Karamoja

It is worth noting that modern medicine in Karamoja, like in the whole of Uganda, is wholly imposed and alien as regards to management, drugs, buildings, and to a large extent ignores traditional approaches, it seems to assume that all its inputs must be imported (Wabwire 1993:58).

Government facilities are free, but many are so drained of resources that even aspirin is hard to come by. The major impacts of neoliberal structural adjustment can be seen clearly in pastoral area. The health service is heavily reliant on missionary and church help, and the church organizations are well respected in the region (Mkutu 2008:94).

Pastoralists' Use of Biomedicine

Approximately 50 to 60 million nomads throughout Africa have insufficient access to or infrequently use biomedical healthcare. Sheik-Mohamed and Velema (1999) link this to the comparatively high cost of biomedicine, the incompatibility of indigenous and Western forms of medicine, and inadequate (both in terms of quality and number) mobile health units designed to reach pastoralist populations. Because pastoralists must often travel long distances to reach biomedical health facilities in trading centers or towns, many nomadic groups utilize biomedicine solely for treatment rather than preventative measures (Shell-Duncan, Shelley, and Leslie 1999:21). For example, at the Morulem Leprosy and Tuberculosis Center in Moroto District, one healthcare worker reported that members of the surrounding nomadic population only traveled to the health center when their tuberculosis had reached advanced stages (Sheik-Mohamed and Velema 1999).

Pastoralists' low reliance of biomedicine is also a reflection of their mistrust of government-funded programs due to colonial and postcolonial attempts to settle

or modernize them. Pastoralists may fear biomedicine as an additional scheme to convince them to give up their livelihoods and identity (especially when biomedicine is promoted as a replacement for historical healing methods and local specialists). Proposed methods to increase utilization include: providing mobile clinics, in which trained clinicians travel to nomadic homesteads mainly as part of immunization campaigns; training indigenous community health workers (CHWs) and traditional birth attendants (TBAs); and convincing pastoralists to adopt a more sedentary way of life (ibid:702-704). However, these notions do not address pastoralists' self-defined needs or strategies to incorporate biomedicine into their existing cultural practices.

Across the globe pastoralists are becoming increasingly sedentary, which has altered both their health risks and their healing methods. Sedentarization occurs for a variety of reasons: livestock losses through governmental destocking programs, cattle raids, and disease outbreaks; perceived benefits of town life; reduction of land and water rights; and agricultural and development schemes. The sedentary life, in theory, also increases pastoralist communities' access to biomedicine. But has biomedical intervention increased and improved individual health and community well-being? Recent research on sedentarization concludes that the overall health of pastoralists has not improved (Fratkin, Nathan, and Roth 1999, Fratkin and Roth 2005, Gray, Akol, and Sundal 2007, Gray et al. 2003, Little and Leslie 1999, Roth 1994, Sundal 2002) due to different health threats associated with a sedentary lifeway,

such as a reduced access to animal protein sources (livestock's milk and blood), crowded living conditions, and poor sanitation.

The use of biomedicine among pastoralists, both nomadic and recently settled, has not been widely studied. Previous research among East African pastoralists (Fratkin 1996, Shelley 1985) indicates that these societies incorporate myriad healing resources, such as medicinal plants, indigenous healers, drug vendors, and biomedicine. Furthermore, settled pastoralists do not solely rely on biomedicine but maintain a strong reliance on indigenous forms of healthcare. In this chapter, I investigate the rise of biomedicine in Karamoja with a specific emphasis on the four biomedical health centers that Karimojong informants utilized. First, I examine the development of Uganda's biomedical system from independence to its current healthcare delivery system. Second, I review the varying roles of the GoU in the implementation of biomedicine at both national and local levels and of NGOs and FBOs, to uncover their impact on Karimojong health. Third, I review available biomedical health facilities in Moroto District and compare and contrast four of these: two designated subcounty centers and the two district hospitals. I conclude the chapter with narrative of Karimojong encounters with biomedicine: how they incorporate it into their healing regimes and their experiences and opinions of the four health centers.

Uganda's Changing Healthcare System

Uganda had one of the best biomedical healthcare systems in East Africa at its independence in 1962 (Devlin 1998, Dodge 1987, Scheyer and Dunlop 1985,

Whyte 1991). The Makerere Medical School and the Mulago National Hospital and Complex (both currently located in Kampala) were ranked among the best hospitals in Africa (Dodge 1987). To maintain this status and to build on the British-imposed biomedical system, the GoU established the Plan III (1966-1971) development scheme. Plan III's objective was to improve rural biomedical access and utilization through free curative services and the construction of new health facilities throughout Uganda. During the implementation of Plan III Uganda had more than 400 health units, offered free basic health services, and had reduced the prevalence of major contagious diseases. In addition to the government-run health facilities, missionary hospitals, prisons, army barracks, and corporations also provided healthcare at a minimal charge.

Idi Amin effectively destroyed Plan III. During his administration (1971-1979) government services completely broke down, food and water shortages plagued hospitals, and immunization programs stopped (Scheyer and Dunlop 1985). In 1973 Amin expelled all Asian residents, and in 1974 he banned private medical practices. Both of these acts greatly reduced the number of Western-trained healthcare professionals. For example, Uganda had one biomedical doctor for every 15,000 people in the 1960s, but after Amin's reforms this ratio dropped to one per 27,000 (Devlin 1998:14). Furthermore, during Amin's regime 80 percent of the pharmacists and 50 percent of the doctors left Uganda (Hutchinson 1999). As discussed in chapter two, Amin's regime had additional, deadly consequences for Karamoja, which heightened local distrust of both the government (i.e., military

forces) and government-sponsored programs, such as immunization campaigns (Verswijver 2004, Wilson 1985).

One of the largest declines in services during Amin's years was the shortage of pharmaceuticals, which led to decreased patient attendance at government health centers (Whyte 1991). Although health services across the country declined, rural areas were the most affected by Amin's healthcare policies (Scheyer and Dunlop 1985:25-30). According to Whyte (1991), rural facilities already lacked biomedical practitioners; thus, the limited drug supply hit these units the hardest. After Amin was forced from office, the United Nations Children's Fund (UNICEF) began the Essential Drug Programme in 1981 to increase the drug supply. In 1985 the Danish Red Cross funded the Essential Drugs Management Programme to distribute 26 pharmaceutical drugs to rural health units in Uganda, including those not supported by the GoU. Whyte (1991:133) reported that although 809 rural health centers received these kits, one-third were unaccounted for because they were moved "out of health facilities through 'informal' channels'" (i.e., staff sold the free drugs to patients for personal profit).

The Ugandan government also sought to bring biomedical care services back to their pre-Amin functioning levels through economic revitalization. Amin's successors, however, "expended almost all their energies in the struggle for power, wealth, and status, with little left for development....[and] utilised the state apparatus to exacerbate parochial loyalties in their persistent search for personal gains" (Tindigarukayo 1988:622). Furthermore, the period between Amin and the

current administration of Yoweri Museveni resulted in the most deadly civil war of Uganda's history. In fact, the Obote II regime (1980-1985) was responsible for at least 300,000 civilian deaths (Tindigarukayo 1988:617). Apart from the devastating civil war, Obote's greatest impact was his dependency on a mixed economic strategy that relied on private investment and international aid through agencies such as the International Monetary Fund (IMF). The IMF reforms, implemented in 1981, did not achieve long-term success, and healthcare improvements were not realized. In fact, the IMF conditions negatively impacted Uganda: IMF devalued the Ugandan shilling and diverted the majority of Uganda's earnings to the Kenyan market; Uganda's industrial sector shrunk by 22%; and Uganda's infrastructure was completely neglected. "Medical service came to a complete standstill" (Mugenyi 1991:64).

Decentralization and Structural Adjustment

In 1986 the National Resistance Movement (NRM) gained control and decentralized the Ugandan government. As a result local governments are now based on a tiered local council system: LCI representatives are directly elected officials; LCII officials serve at the parish level; LCIII represent the subcounty; LCIV administer at the county level; and finally, the highest ranking LCV represent the district level. This fragmented system stokes tensions, especially in Karamoja where only the younger, educated elite fill the higher LC positions, while uneducated rural residents are confined to the LCI spots (Stites et al. 2007:19-20). Museveni also established the state minister for Karamoja affairs, an appointment within the prime

minister's office to oversee the "special" needs (e.g., conflict resolution, aid, and development) of Karamoja (Mkutu 2008).¹⁸

As part of the 1987 Economic Recovery Programme, the Museveni administration accepted the IMF and World Bank Structural Adjustment Program (SAP). In 1984 the civil war halted previous SAP implementation; it was not until the current administration took office that SAP policies became commonplace in Uganda (Lateef 1991). SAPs have been highly criticized for their worldwide detrimental impact in poor nations, including Uganda, due to the slashing of public programs and funding. "The required structural adjustments often cut into public expenditures for education, free or subsidized health care, and social welfare programs...." (Scheper-Hughes and Sargent 1998:3).

The NRM also reconfigured the Ministry of Health (MoH). The goal of MoH's decentralization was to improve biomedical care through reduction in overlapping services and to make the local government responsible for resource allocation. Administrative districts were to plan, implement, and manage all public health services with the following governmental personnel: a district health council composed of elected officials; a district health commissioner elected into the district health council; a district director of health services (the former district medical officer) employed by the district health council; and technicians (health inspector, health visitor, leprosy and tuberculosis control supervisor, health educator, and

¹⁸ In February 2009 President Museveni appointed his wife, Janet Museveni, as the new state minister for Karamoja affairs.

medical superintendent) who functioned as the district health team (Hutchinson 1999:90).

The World Bank Report, *Healthcare in Uganda: Selected Issues*, (Hutchinson 1999:74-75) found several problems with decentralization: government-run health units offered lower quality of care than privately owned units; MoH retained control of funding for personnel and drug supplies, which removed control from the district-level; and funding decisions were based on the number of beds a health unit had rather than actual needs of the district or community.

The MoH built partnerships with NGOs and private donors and implemented fee-based services in 1989, a direct result of SAPs prevalence throughout Africa, which “compelled governments to slash down public expenditure, doing away with free and subsidised healthcare and adopting market based services” (Mkutu 2007:52). Children under the age of five, accident victims, and the chronically ill were exempt from paying for services, but the very poor had to obtain fee waivers. Although the fee-based system intended to improve the quality of biomedical care, profits in fact were misused to support staff salaries (Hutchinson 1999).

In 1999, the Museveni administration published the national health policy, which outlined measures to revitalize Uganda’s healthcare sector through improved communication and support among private and governmental health units. In July 2000, the MoH extended this policy with the Public-Private Health Partnership (PPHP). PPHP’s current aim is to improve Ugandan health overall through a

comprehensive biomedical care system. The health partnership identifies three groups of private healthcare providers: not-for-profits, including NGOs and FBOs; private biomedical practitioners; and “traditional and complementary medical practitioners” (MoH www.health.go.ug). Although PPHP named local (complementary) health practitioners as one of the three partners necessary for strengthening the healthcare sector, the majority of funding and support still target Western-based medicine and ideology. Indigenous healers, especially in Moroto District, remain on the fringe of the current health system.

Private Practices

Certification of private biomedical facilities is fraught with problems due to overlapping monitoring agencies and unclear policies. The Uganda Medical Council’s licenses qualify physicians to examine patients and prescribe and administer pharmaceuticals (or authorize the dispensary to give the drugs) but not to sell drugs, whereas pharmacists (licensed by the Uganda Pharmaceutical Board) can sell drugs but not examine patients (Whyte 1991). In practice, the responsibilities of doctors and pharmacists are often blurred. No real restrictions on drug training or the distribution of drugs are enforced; and the majority of pharmaceuticals, including antibiotics, are sold without a prescription at local drugshops. Furthermore, some government workers are dually employed at the government health center as well as at private clinics or even own private drugshops. Privately run facilities have increased since the 1980s. Before Amin expelled Asian residents, private clinics only existed in the major towns. By the mid-1980s, however, rural

private clinics were found throughout Uganda. Whyte summarizes private practices in one eastern district of Uganda, stating “nearly every trading centre now has at least one clinic being run by a governmental health worker who has rented premises where people come for examination and treatment. Many have drug shops as well” (Whyte 1991:134). This poses a particular problem in maintaining drug supplies at free governmental health facilities because workers funnel drugs from the government-sponsored unit to their own private practice.

Healthcare Funding and Classification

The MoH ranks all biomedical health centres (HC) throughout Uganda according to facility size, number of biomedical professionals on staff, and the services offered; health units are ranked as HC II, HC III, or HC IV (Table 5.1). As shown in Table 5.1, the level two units (HC II) offer outpatient biomedical care through the distribution of pharmaceuticals, immunizations, and antenatal care. HC II units function as drug dispensaries and do not provide medical examinations for patients. The MoH requires that HC II facilities employ at least one nurse, one midwife, and two nursing assistants, but not all HC II units meet the minimal staff requirements (as exemplified by the dispensary in this study). No doctors are required to work at HC II facilities.

In addition to all of the HC II services, level-three units (HC III) provide inpatient care and employ at least eight healthcare staff. HC III units theoretically provide biomedical care at the subcounty level, but in practice this is not always true. For example, in Moroto District only two subcounties have drug dispensaries

(HC II) as their designated units. HC IV units provide the most comprehensive biomedical care, including inpatient and outpatient care, laboratory and x-ray services, and surgical procedures. HC IV facilities have at least 21 employees, including registered midwives, a medical physician, a comprehensive nurse, and a dental assistant. HC IV units are the health headquarters for the county level, supervise all other health centers, and collect and analyze health data for their counties.

Table 5.1 MoH Classification of Health Centres (HC) (www.health.go.ug)

Heath Centre	Support Level	Responsibilities	Services	Staff
HC II	Parish	Drug dispensary	<ul style="list-style-type: none"> • Outpatient care • Immunizations • Ante-natal care 	1 nurse 1 midwife 2 nursing assistants
HC III	Subcounty	Clinic	<ul style="list-style-type: none"> • Outpatient care • Inpatient care • Immunizations • Ante-natal care • Environmental services 	1 clinical officer 1 nurse 1 nursing assistant 1 health assistant 1 laboratory assistant 1 records officer 2 midwives
HC IV	County	Subdistrict headquarters: collect and analyze data at the subdistrict level; supervise all other health units	<ul style="list-style-type: none"> • Outpatient care • Inpatient care • Immunizations • Ante-natal care • Environmental services • Surgical procedures 	Minimum of 21 employees: <ul style="list-style-type: none"> • registered midwife • medical officer • comprehensive nurse • dental assistant

Another characteristic of decentralization is the increased presence of NGOs in Uganda's health sector. NGOs can directly own or run healthcare facilities. In fact, the Church of Uganda is a key administrator of community-based healthcare in Karamoja. In the early 1990s, it supervised 13 biomedical projects throughout Karamoja and employed approximately 50 healthcare workers. The Church of Uganda claimed to have designed its community programs to include recommendations from community elders and indigenous health practices (Wabwire 1993:56). Even so, the Church of Uganda's long-term curative and preventative biomedical services are still underutilized by the Karimojong, as shown in the informants' experiences discussed below.

NGOs also serve the health centers through logistical, structural, and financial support. For instance, the Comboni Mission Society and the Italian Cooperation (ItalCoop) serve as umbrella organizations for several faith-based health programs and social services (ItalCoop 2006). Two of the Italian Cooperation's organizations – the Association of Volunteers in International Service (AVSI) and the "University College for Aspiring Missionary Doctors" (Doctors with Africa, a NGO functioning as part of CUAMM) – in conjunction with UNICEF, now support Uganda's Health Sector Strategic Plan (HSSP) to implement a primary healthcare package throughout Uganda. The MoH launched HSSP¹⁹ in 2000, which mandated that a steady drug supply, pharmaceutical treatment for HIV/AIDS, tuberculosis, and malaria, emergency care, and birth registrars be available for each

¹⁹ Phase one of HSSP (HSSP I) was the five-year plan for 2000-2005, whereas HSSP II will conclude in 2010.

district (ItalCoop 2006:28). The Italian Cooperation also founded the Karamoja Data Centre – now managed by the Office of the Prime Minister – to analyze and collect District level demographic and health statistics.

In 2003, the Church Health Commission (CHC, also referred to as the Church Medical Commission) formed to reduce competition among religious healthcare providers (Kawasaki and Patten 2002). The Uganda Catholic Medical Bureau (UCMB) and the Uganda Protestant Medical Bureau (UPMB) were founded in the late 1950s to distribute biomedical supplies and are the two largest supervisors of faith-based clinics in Moroto District (UCMB www.ucmb.org, UPMB www.upmb.co.ug). The religious-affiliated medical bureaus also serve as liaisons between the MoH, funding partners, and religious organizations (churches within the appropriate denomination and members of the bureau). The UCMB and UPMB are the “technical arms” of CHC (Figure 5.1). The UCMB works with the Roman Catholic Church and its Catholic-based health units to operate 27 hospitals, 11 training schools, and 203 lower-level health clinics throughout Uganda (UCMB www.ucmb.co.ug). The UPMB serves the Protestant Church and its health facilities. The Uganda Muslim Medical Bureau (UMMB) and the Islamic Medical Association of Uganda (IMAU) also manage faith-based health units in Uganda, but they are not active in Moroto District.

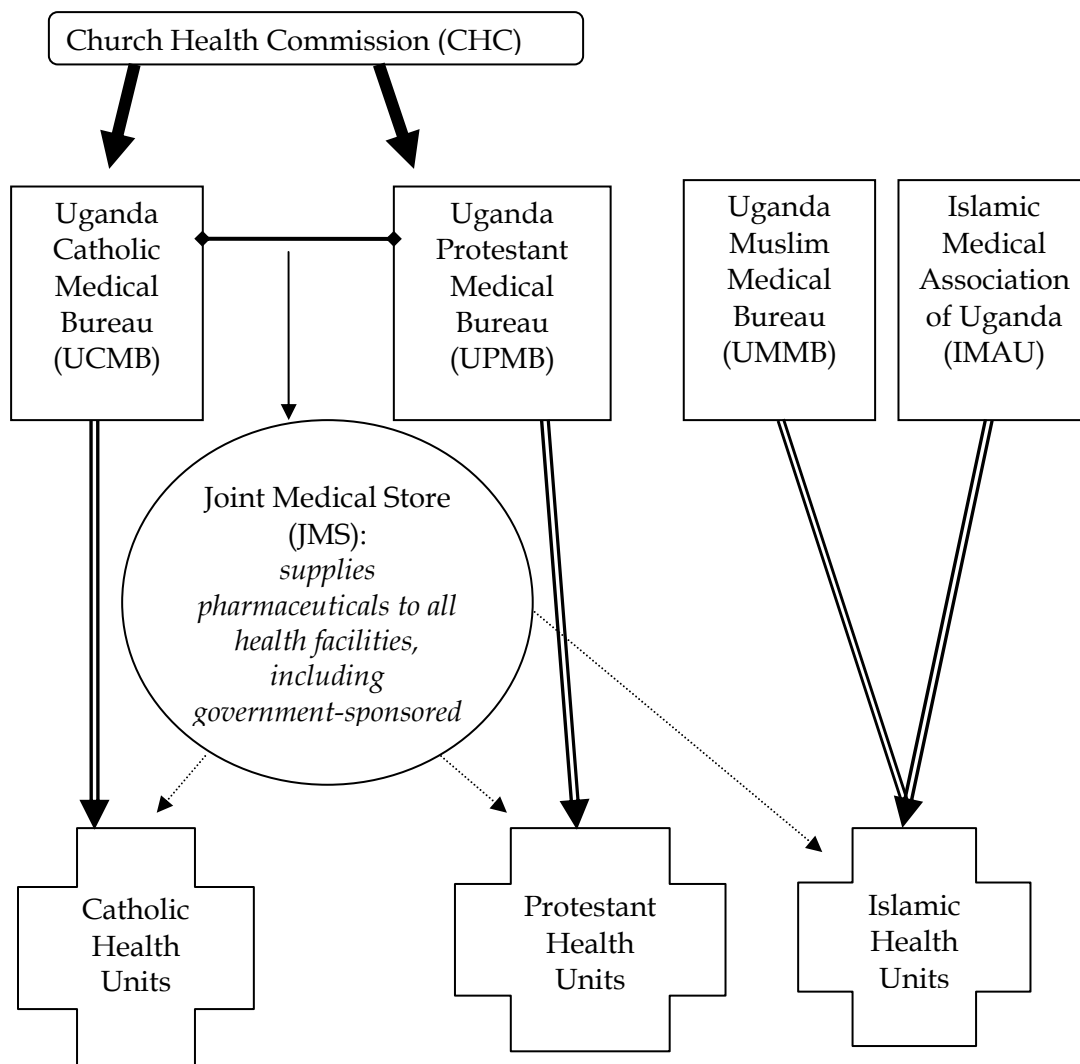


Figure 5.1 Hierarchy of Faith-Based Health Units in Uganda

One key responsibility of both the UCMB and UPMB is to distribute biomedical pharmaceuticals to the healthcare facilities. In 1979 these two agencies founded the Joint Medical Store (JMS), a drug procurement organization. The JMS purchases its drug supply from both within and outside of Africa and sells on a cash-and-carry basis (Kawasaki and Patten 2002). The JMS supplies biomedical drugs to 40 percent of the healthcare facilities (which accounts for approximately 25

percent of the drug supply) within Uganda, including 330 mission-supported health units (Kawasaki and Patten 2002:21-25). All UCMB and UPMB member health units in Moroto District use pharmaceuticals and biomedical supplies obtained from JMS.

Moroto District Health Units

Drs. Mitford Barbiton and Robert Karrach opened the first health center and dispensary in Karamoja in the 1950s (Cox 1985:173). The early unit was designed for primary biomedical care and conformed to national healthcare standards. Today national and local governments and NGOs (mostly FBOs) fund, administer, and provide biomedical care for all 84 biomedical centers in Karamoja.

In Moroto District, there are 16 biomedical health units: two HC IV hospitals; eight HC III, and six HC II (Table 5.2). Although local and national government supports 60 percent of the health units and NGOs fund the remaining 40 percent, the District Medical Office located at the district headquarters in Moroto Town oversees all health centers and monitors each through monthly patient usage reports. One hundred and thirty-five healthcare workers (only eight of which are doctors) staff the 16 Moroto health units. Numerous drugshops – stores that sell pharmaceuticals, including antibiotics and injections, as well as other household goods – exist in Moroto District’s towns and trading centers, but none are officially registered with the District Medical Office.

Table 5.2 Moroto District Biomedical Facilities (www.health.go.ug)

County	Subcounty	Parish	Unit	Grade	Sponsor
Bokora	Irii	Irii	Irii	HC III	GoU
	Irii	Lorengacora	Lorengacora	HC II	(not listed)
	Lotome	Moruongor	Lotome	HC III	GoU
	Lokopo	Apeitolim	Apeitolim	HC II	GoU
	Lopee	Lopee	Lopee	HC II	GoU
	Matany	Lokuwas	Matany St. Kizito Hospital	HC IV	FBO: St. Kizito Comboni Mission
	Ngoleriet	Lokoreto	Kangole Catholic Mission Dispensary	HC III	FBO
	Ngoleriet	Nawaikorot	Ngoleriet	HC II	GoU
Matheniko	Katikekile	Kakingol	Kakingol	HC II	(not listed)
	Katikekile	Tapac	Tapac	HC III	FBO: Italian Cooperation & Development
	Nadunget	Loputuk	Loputuk	HC II	FBO: Italian Cooperation & Development
	Nadunget	Nadunget	Nadunget	HC III	GoU
	Rupa	Moroto Army Barracks	Moroto Army Barracks Dispensary	HC II	GoU
	Rupa	Rupa	Rupa St. Pius Naoi Kidepo	HC III	FBO
	Moroto Municipality	Moroto Town	DDHS (Director of District Health Services) Clinic	HC II	GoU
	Moroto Municipality	Moroto Town	Moroto Hospital	HC IV	GoU

Each of the two subcounties sampled in this study have one designated health center. According to the MoH, these units serve only people living within the corresponding subcounty; thus, if a woman traveled to a neighboring subcounty's health center she would be turned away because she did not live there. In practice this did not hold true as patients manipulated the system (i.e., held two different health cards each showing a different subcounty residency) to fit their needs. Mothers also reported that instead of visiting their own subcounty health center as their first course of action, they would either go directly to the county hospital or go to local drugshops to buy pharmaceuticals.

Informants frequented numerous health facilities, but relied consistently on the four following centers: Lopeei HC II dispensary in Bokora; St. Kizito Hospital in Bokora; Rupa HC III clinic in Matheniko; and Moroto Hospital in Matheniko. The dispensary and the district hospital (Moroto) were under direct control of the GoU, whereas the remaining two were mission-based.

HCII Dispensary

Lopeei subcounty's health center is a level-two free dispensary in Bokora County run by the GoU (Figure 5.2). This dispensary had five employees in 2007—two nurses, two nursing assistants, and one general worker—but did not have any certified midwives, a requirement of HC II status as defined by the MoH. The out-patient clinic consisted of three rooms—out-patient consultation, treatment, and administration—and provided basic medical services, such as drug distribution when pharmaceuticals were in stock. Patient diagnoses at this dispensary were not

determined through physical examinations, but were formed during patient consultation and from verbal recall of symptoms. The health center grounds also contained staff living quarters and a drug storage building.



Figure 5.2 HC Level II Drug Dispensary

Although there were housing quarters on site, no staff lived on the premises; all staff lived at least a 30-minute car ride away and traveled daily via bicycles or on foot. Thus, the dispensary's operational hours were limited (official operational hours were Monday through Friday, 9:00 a.m. – 2:30 p.m.), and Karimojong informants reported that the dispensary opened late and closed early. The dispensary was a several-hour walk (one way) from the villages I sampled; informants described how after a long walk to the dispensary they often waited for the staff to arrive, stood in long lines to be seen, and once diagnosed, they were informed that the drug stock was empty. Mothers reported that the government units lacked pharmaceuticals more regularly than missionary-based centers because government staff sold the drugs in privately owned stores (Sundal 2008). A trip to

the dispensary easily became an all-day event that might result in no curative measures.

Karimojong informants also reported that insecurity greatly impacted all health centers in Moroto District. Because biomedical facilities have become the target of armed robberies, medical supplies and staff are in short supply. For example, in 1999 Medicines Sans Frontier (MSF) terminated its healthcare rehabilitation project after numerous attacks on staff (Gray et al. 2003). Furthermore, insecurity has discouraged many biomedical professionals from working in Karamoja. According to Narman (2003:130), “medical staff are seldom properly trained and health centres are not well equipped. Due to the general insecurity, thefts of drug and other medical equipment are common.” Staff at the Lopeei dispensary stated (personal communication 3/7/07) they could not live on the health center grounds because it was unsafe – the metal outer fence did not enclose the entire property and there were successive cattle raids in the neighborhood. These security complications also restricted patient access because informants felt it was dangerous to walk to the dispensary. The health center’s staff echoed these fears and explained that during times of frequent raids or disarmament operations they believed the risk of commuting to work was far greater than their need to open the dispensary.

HC III Clinic

In contrast, the HC III unit in Rupa subcounty is a faith-based facility (under the UCMB) that provided both in-patient and out-patient care, including

examinations, on a 24-hour basis. Staff (personal communication 4/2/07) attributed their ability to receive patients at all hours to the fact that they lived on site and that a well-built, secure fence surrounded the entire grounds. Although the fence made the health center relatively safe, the surrounding area had been the target of numerous cattle raids, making it unsafe at times for staff to leave the grounds or for patients to enter. The Rupa health center also owned an ambulance service, which could transport critical patients to Moroto Hospital, a highly valuable service for rural patients. This unit also operated a small laboratory facility, maintained a drug store, and had built a maternity ward. Staff however indicated that the maternity ward was rarely used because the surrounding community preferred to deliver their babies at home. Staff at the HC III facility were more numerous and varied in expertise than those employed at the Lopeei dispensary and included nurses, nursing assistants, and laboratory assistants. In 2007 the clinic was also building a new community center and housing to attract one or two doctors, a requirement to upgrade to HC IV status.

While the HC III clinic offered more comprehensive services than the HC II dispensary, it was not without its faults. The most repeated complaint by informants concerned clinic fees. Specifically, mothers felt that the Rupa nurses took advantage of their illiteracy. At the entrance to the main building a large sign posted the clinics fees: 500 shillings to treat children and 1,000 for adults. Mothers explained how the nurses deceived them by pointing to the sign and telling them that the charges had been raised and they would not administer any drugs unless the mothers paid the

additional money. These women felt duped when they returned home to find that, in fact, the rates had not been raised. During a mass child immunization day at the Rupa clinic, I joined one mother as she waited in line with her infant (AD120 4/18/07). The nurse had overcharged her but had explained that she would get the balance back at the end of the day. The nurse never paid the money and my informant did not challenge her. When I asked why she did not demand her money back (or why I could not go talk to the nurse on her behalf), this woman explained that if she made a scene the nurse would be furious and could even withhold treatment on subsequent visits.

Families attending the immunization day were also supposed to receive sugar and soya-blend flour, the same nurse reported that the sugar was out of stock. Women dutifully lined up to receive their flour portions and surprisingly few complained about the lack of sugar. At the end of the distribution the nurse asked me for a ride to town. She climbed into my vehicle with large plastic bags full of sugar. My research assistant quickly told me to be quiet and reiterated my informant's sentiments later that evening—if I had confronted the nurse the informant would face future punishment.

Moroto Hospital

The district's two hospitals differed according to services provided, fee schedules, and supporting agencies. Moroto Hospital is the government district hospital and is located in the center of Moroto Municipality in Moroto Town, approximately 30 kilometers from the Ugandan-Kenyan border. It is "poorly

equipped and staffed by nurses and a doctor” (Mkutu 2007:39). Moroto Hospital has several wards, 90 in-patient beds, and an outdoor communal area in which patients or their caretakers may launder clothes, prepare and eat meals, or relax. Moroto Hospital provides free services to the community, but this is misleading.

Karimojong informants reported that Moroto Hospital frequently underwent drug and supply shortages; thus, patients were responsible for providing their own medical supplies, which they bought at nearby drugshops. Informants complained that hospital staff recommended the particular drugshops that they themselves owned and suspected that staff looted the hospital’s stock to sell for personal profit. Women specifically complained about Moroto Hospital’s nurses who slap patients, demand monetary bribes, or cause drug stocks to run low. For instance one mother stated,

They shout at people who bring patients in who are really sick or who have delayed. If it is a very severe sickness the staff will just tear up your health form and tell you to go away. This happened to me when my daughter was sick. I was slapped because they thought I had delayed and my child was about to die (AD78 4/7/07).

Seven Matheniko women (of the 12 Matheniko mothers) reported some form of physical and verbal abuse from Moroto Hospital staff. Other mothers and healers confirmed these findings through their stories of witnessing abuse of other patients. One informant described how the Moroto “nurses shout at us where to sit, scold us for not bathing, and slap us if we don’t know the rules of the place” (MP6 4/11/07). Mothers also contended that nurses and other staff at Moroto Hospital covertly charge money for services (Sundal 2008). Six Matheniko mothers recalled that they

had to pay nurses before care was administered. One woman explained, “sometimes the nurses say if you don’t give them money they won’t treat you. This is not good, but the sickness is what brings you to the hospital and nurses control the drugs. The hospital is to be free, but what can you do?” (AD3 4-4-07).

St. Kizito Hospital

Eighty kilometers from Moroto Hospital is the district’s second hospital, St. Kizito, located in the Matany trading center of Bokora County. St. Kizito is a fee-based, missionary hospital (under the Catholic Diocese of Moroto) and is linked to the Italian Comboni Missionary Society and the Italian Cooperation for Development (St.Kizito 2003/04, 2007, Mkutu 2007). Even though St. Kizito Hospital is not-for-profit, it does charge patients for its services; although, it has attempted to keep charges at a minimum “due to the extreme poverty of the population” (Kizito 2007:4). Oxfam funded the initial construction of St. Kizito, which when completed in 1969 was only a dispensary and a maternity ward staffed by two Comboni nuns. Two years later, the hospital officially opened but employed only two physicians. In 1974 Doctors with Africa became the financial supporters of St. Kizito and in 1997 the Ugandan government began to supplement these finances. In 2005 the hospital started to receive essential drug support from the GoU as well. In fact, the GoU covers approximately 22 percent of the hospital’s costs, with patient fees and external donations supporting the rest (Kizito 2007).

St. Kizito Hospital is not only the designated health unit for Matany subcounty and serves as the main out-patient facility for Matany residents; it is also

the administrative headquarters for all other Bokora health centers, a direct result of the MoH decentralization policies. “The decentralization policy carried on by the Ministry of Health has lead [sic] Matany [St. Kizito] Hospital to become the referral facility of Bokora Health Sub-District with a central role in planning, supervise [sic] and monitoring all health activities in the area” (Kizito 2007:11). The surrounding Bokora subcounties have smaller, lesser grade health units that serve as their primary facilities. St. Kizito, therefore, may not be the first health unit for Karimojong living outside of Matany who do not want to go to their designated units or a referral unit after designated health centers find they are unable address their constituents’ needs. The hospital also supports the Bokora peripheral health centers through immunization programs and monthly training of TBAs within each subcounty.

St. Kizito treats approximately 15,000 in-patients and provides consultations for 30,000 out-patients each year, the largest proportion in Karamoja. Staff attributed this to its medical equipment and large wards. In fact, this hospital contains 226 beds in five departments: obstetrics/gynecology, internal medicine, tuberculosis ward, pediatrics, and surgery. In addition to these in-patient facilities, St. Kizito has an HIV/AIDS clinic, out-patient examinations, diagnostic imaging, orthopedics, counseling, and a laboratory.

The St. Kizito complex, which comprises the hospital, a nurse training school, a human resource development center, and a machine shop, employed 230 staff in 2007. Staff included biomedical practitioners (medical officers and allied medical

professionals), nurses, administrative employees, primary healthcare staff who monitored peripheral Bokora health units, support staff, nursing school employees, and members of the Karamoja Human Resources Development Centre for Health.

Bokora mothers were generally pleased with the biomedical care administered at St. Kizito Hospital. In fact, only one informant criticized St. Kizito's nurses:

The hospital services are good. I have never been mistreated myself, but sometimes the nurses mistreat those who delay at home and then take a child to the hospital when he is at a critical stage. The nurse becomes harsh and if the mother quarrels or if the mother is drunk, then the nurse can slap her. The nurse is really just trying to do her work though and if the mother is drunk the slap will make her come to her senses (AP98 3/2/07).

Overall, mothers reported that St. Kizito had well-stocked and high-quality pharmaceuticals, offered services that were not available elsewhere (such as blood analyses and surgery), and had comprehensive medical equipment. Even Matheniko informants (who rarely used St. Kizito, but instead relied on their county hospital, Moroto Hospital) spoke of St. Kizito's superior reputation over Moroto Hospital. One mother stated, "x-ray and the sampling of blood and phlegm are at Moroto, but they are not as good as those of St. Kizito" (AD155 4/8/07). I was surprised by the consensus on St. Kizito's quality, not because I found that St. Kizito's services were lacking – they are the most comprehensive in Moroto District – but because this hospital is both fee-based and located far from informants' home communities. I had expected more mothers to complain both about St. Kizito's service charges as well as the long commute it took to get there. .

Reliance on Biomedicine

Karimojong mothers (26 total from both the mothers and combined sample) readily spoke about how they used biomedicine in conjunction with local remedies. All mothers reported they had utilized biomedicine in the past. Eighty-one percent of the mothers had frequented a biomedical health facility, either for themselves or for their children, within the six months prior to the date of the interview, whereas 19 percent stated it had been longer than six months since they had gone to a biomedical health unit. Fifteen of the mothers, in fact, had gone to the health unit within the previous four weeks. Furthermore, twenty-five mothers used more than one health unit: eleven stated they relied on two units; ten used three units; and four attended three biomedical units.

Karimojong mothers frequently bought pharmaceuticals – both at the advice of Western health practitioners (i.e., if the health units' drug stocks were empty) and on their own accord. The level of care provided at drugshops varied throughout the district. The majority of the drugshops were located in the more urban (or semi-urban) locales – Moroto Town, Matany trading center, and Kangole trading center – but small shops existed in rural trading centers as well. Mothers explained that they often borrowed pharmaceuticals from their neighbors or purchased them from drugshops before going to the health facilities. A common strategy for extended illness bouts was administering pharmaceuticals (commonly panadol, flagyl, or septrine) as one of their first strategies or in conjunction with herbal remedies,

because drugs and local herbs were the cheapest and most readily available treatments.

Moroto District Health Data

From the Moroto District Medical Office, I obtained district, county, and subcounty (Lopee and Rupa) out-patient reports from January to May 2007. For the subcounties I also collected the 2006 monthly reports. According to the medical records clerk (personal communication 6/18/07), each health unit tallies monthly illness diagnoses and submits them to the county administrative unit (either St. Kizito or Moroto hospitals), which aggregates the county data and forwards all paperwork to the district medical office. The records tallied out-patient attendance (including the number of new and returning patients), children's immunizations, and illness diagnoses subdivided into 61 categories of communicable, noncommunicable diseases, and maternal and perinatal conditions (Figure 5.3).

OPD ATTENDANCE AND LABORATORY TESTS TOTALS FOR THE YEAR									
OUTPATIENT ATTENDANCE					LABORATORY TESTS				
Category	0-4 years		5 and over		Category	Number of tests done		Number Positive	
	Male	Female	Male	Female		Male	Female	Male	Female
New attendance					Malaria blood smear				
Re-attendance					TB sputum				
Total Attendance					Syphilis screening				
Referrals to unit (all ages)					Pap smear				
Referrals from unit (all ages)					Other Lab. Tests				

OUTPATIENT DIAGNOSES									
Diagnosis	0-4 years		5 and over		Diagnosis	0-4 yrs		5 and over	
	Male	Female	Male	Female		Male	Female	Male	Female
Epidemic-Prone Diseases					Other Infectious/Communicable Diseases				
01 Acute flaccid paralysis					13 AIDS				
02 Cholera					14 Diarrhea- Acute				
03 Dysentery					15 Diarrhea- Persistent				
04 Guinea worm					16 ENT conditions				
05 Meningitis (meningococcal)					17 Eye conditions				
06 Measles					18 Sexually Transmitted Infection (STI)				
07 Tetanus (neonatal)(0 -28 days age)					19 Urinary Tract Infections (UTI)				
08 Plague					20 Intestinal Worms				
09 Rabies					21 Leprosy				
10 Yellow Fever					22 Malaria				
11 Other Viral Haemorrhagic Fevers					23 Other types of meningitis				
12 Other emerging infectious disease (Specify)					24 No pneumonia - Cough or cold				
Maternal and Perinatal Diseases					25 Pneumonia				
35 Abortions					26 Schistosomiasis				
36 Malaria in pregnancy					27 Onchocerciasis				
37 High blood pressure in pregnancy					28 Skin Diseases				
38 Obstructed labour					29 Tuberculosis (New cases)				
39 Haemorrhage related to pregnancy (APH &/or PPH)					30 Typhoid Fever				
40 Perinatal conditions (in new borns 0 - 28 days)					31 Tetanus (over 28 days age)				
Non-communicable diseases					32 Sleeping sickness				
41 Anaemia					33 Pelvic Inflammatory Disease (PID)				
42 Asthma					34 Deaths in OPD				
43 Oral Diseases and Conditions					More Non-communicable diseases				
44 Diabetes mellitus					53 Epilepsy				
45 Gastro-Intestinal disorders (non-Infective)					54 Other forms of mental illness				
46 Hypertension					55 Other cardiovascular diseases				
47 Anxiety disorders					56 Severe Malnutrition (Marasmus, Kwashiorkor and Marasmic-kwash)				
48 Mania					57 Low weight for age				
49 Depression					58 Injuries- Road traffic Accidents				
50 Schizophrenia					59 Injuries= (Trauma due to other causes)-				
51 Alcohol and Drug abuse					60 Animal/ snakes bites				
52 Childhood Mental Disorders					61 Other diagnoses (priority diseases for District)				
					All others				
					Total Diagnoses				

Figure 5.3 Disease Reporting Form for Moroto District Health Units

Little detail can be gleaned from these records. Patients were lumped into four broad categories: males younger than five years old; females younger than five years old; males older than five years old; and females older than five years old. These categories do not allow useful analyses of age-related illnesses, such as the infant morbidity rate of malaria or comparisons of adult versus childhood morbidity, because everyone older than five years is lumped in the same category. Furthermore, the reliability of the records is questionable at best. First, the records I examined were incomplete with entire months' worth of data missing. For example, the health facility in Rupa subcounty did not have any patients recorded for August 2006. Second, at times the recorded number of patients who attended the centers was greater than the total number diagnoses. Lopeei's health records for January 2007 exemplifies this: 141 girls under five years old came to the dispensary, but only 126 diagnoses were recorded. Devlin (1998) found similar problems with Moroto District records in her examination of monthly health summaries from 1992 to 1996. Devlin concluded that illness tabulations, as documented by the district medical office, were unreliable. At that time the health records aggregated diagnoses by age categories (but not by sex) across 32-37 categories, depending on the year.

Tables 5.3 and 5.4 summarize the health records for Lopeei and Rupa subcounties' health units. More patients attended the Lopeei HC II unit (10,483) than the Rupa HC III unit (6,905). While this is partly a result of the missing HC III records for August 2006, this may also be attributed to the fact that the Lopeei HC II unit offered free services, whereas the HC III facility charged for its services. From

the monthly records I calculated the prevalence of reported illnesses for each sex and age group in both clinics. Neither health unit reported any cases of the following:²⁰ cholera; meningitis; measles; low weight for age; and alcohol or drug abuse. It is likely that this was a reporting error (i.e., the illnesses were not tallied) or the illnesses were misdiagnosed. These “unreported” illnesses are some of the top killers of Karimojong children. As reported elsewhere (Sundal 2002), from 1940 to 1999, twenty-five percent of children in a sample aged one to four years died from measles; combined diarrheal diseases (including cholera) explained twenty-three percent of the deaths; and meningitis/hepatitis resulted in eight percent of the child deaths. It is also curious that neither health facility in the current study documented low weight for age children, but this may be explained by the fact that children are not weighed at each visit. Recent studies (Gray, Akol, and Sundal 2008, 2009b, Gray et al. 2003, Wiebusch 2002) have found childhood stunting and marasmus to be prevalent among Karimojong children.

²⁰ The Lopeei dispensary did not report any patients in the following 32 categories: acute flaccid paralysis; cholera; guinea worm; meningitis; measles; neonatal tetanus; plague; rabies; yellow fever; other viral hemorrhagic fever; AIDS; persistent diarrhea; leprosy; other types of meningitis; schistosomiasis; onchocerciasis; TB new case; typhoid fever; tetanus (over 28 days); sleeping sickness; pelvic inflammatory disease; deaths in OPD; diabetes mellitus; hypertension; anxiety; depression; schizophrenia; alcohol/drug abuse; childhood mental disorders; other cardiovascular; low weight for age.

The Rupa clinic did not report any patients with the following 30 categories: acute flaccid paralysis; cholera; guinea worm; meningitis; measles; neonatal tetanus; plague; rabies; yellow fever; other viral hemorrhagic fever; persistent diarrhea; leprosy; schistosomiasis; onchocerciasis; TB new case; tetanus (over 28 days); sleeping sickness; deaths in OPD; diabetes mellitus; gastro-intestinal; hypertension; anxiety; depression; schizophrenia; alcohol/drug abuse; childhood mental disorders; other mental disorders; other cardiovascular; low weight for age.

Both centers, regardless of diagnostic method (the dispensary based diagnoses completely on patient recall, but the HC III clinic also provided patient examinations) reported similar disease frequencies. For instance, prevalence of malaria and nonpneumonia cough was highest among their patients (both sexes and all ages). The HC III clinic, however, recorded a higher percentage of patients with acute diarrhea than at the dispensary, whereas the Bokora HC II dispensary diagnosed a higher frequency of sexually transmitted infections, skin diseases, and intestinal worms than the Matheniko clinic. These data offer insight into Karimojong morbidity patterns and out-patient utilization of biomedical units, but do not include any records of in-patient treatment. An accurate understanding of Karimojong usage of Western medicine can not be gleaned from these data alone.

Table 5.3 Lopeei HC II Patient Diagnoses, January 2006-May 2007

	Males 0-4		Females 0-4		Males 5+		Females 5+	
	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
New Attendance	1373		1611		1924		2978	
Re-attendance	393		442		732		1030	
	1766		2053		2656		4008	
<i>OPD Diagnosis</i>								
Dysentery	33	(1.87)	42	(2.05)	53	(2.00)	66	(1.65)
Other	7	(0.40)	2	(0.10)	9	(0.34)	26	(0.65)
Acute Diarrhoea	23	(1.30)	25	(1.22)	28	(1.05)	35	(0.87)
ENT Condition	30	(1.70)	45	(2.19)	32	(1.20)	59	(1.47)
Eye Condition	138	(7.81)	147	(7.16)	79	(2.97)	112	(2.79)
STI	34	(1.93)	63	(3.07)	102	(3.84)	132	(3.29)
Urinary Tract Infection	8	(0.45)	11	(0.54)	54	(2.03)	57	(1.42)
Intestinal Worms	39	(2.21)	49	(2.39)	140	(5.27)	118	(2.94)
Malaria	924	(52.32)	936	(45.59)	866	(32.61)	1499	(37.40)
No Pneumonia--Cough or Cold	444	(25.14)	421	(20.51)	550	(20.71)	857	(21.38)
Pneumonia	6	(0.34)	7	(0.34)	85	(3.20)	66	(1.65)
Skin Disease	111	(6.29)	111	(5.41)	175	(6.59)	170	(4.24)
<i>Non-Communicable Disease</i>								
Anaemia	7	(0.40)	1	(0.05)	1	(0.04)	1	(0.02)
Asthma	1	(0.06)	0		2	(0.08)	11	(0.27)
Oral Disease	22	(1.25)	23	(1.12)	23	(0.87)	33	(0.82)
Gastro-Intestinal	11	(0.62)	10	(0.49)	37	(1.39)	51	(1.27)
Epilepsy	0		0		2	(0.08)	5	(0.12)
Other Mental Disorders	0		0		0		2	(0.05)
Severe Malnutrition	1	(0.06)	0		0		0	
Injuries: Road Traffic Accidents	0		0		1	(0.04)	1	(0.02)
Injuries: Trauma	4	(0.23)	1	(0.05)	35	(1.32)	20	(0.50)
Animal or Snake Bites	0		0		1	(0.04)	0	
Other	103	(5.83)	123	(5.99)	314	(11.82)	396	(9.88)

Table 5.4 Rupa HC III Patient Diagnoses, January 2006-May 2007

	Males 0-4		Females 0-4		Males 5+		Females 5+	
	Cases	(%)	Cases	(%)	Cases	(%)	Cases	(%)
New Attendance	1510		1409		649		876	
Re-attendance	837		697		394		533	
	2347		2106		1043		1409	
<i>OPD Diagnosis</i>								
Dysentery	64	(2.73)	49	(2.33)	13	(1.25)	9	(0.64)
Other	0		1	(0.05)	3	(0.29)	2	(0.14)
AIDS	0		0		0		1	(0.07)
Acute Diarrhoea	373	(15.89)	346	(16.43)	68	(6.52)	45	(3.19)
ENT Condition	23	(0.98)	19	(0.90)	10	(0.96)	19	(1.35)
Eye Condition	200	(8.52)	164	(7.79)	91	(8.72)	118	(8.37)
STI	0		0		4	(0.38)	3	(0.21)
Urinary Tract Infection	2	(0.09)	0		18	(1.73)	12	(0.85)
Intestinal Worms	12	(0.51)	21	(1.00)	26	(2.49)	17	(1.21)
Malaria	1232	(52.49)	1137	(53.99)	450	(43.14)	670	(47.55)
Other Types of Meningitis	1	(0.04)	0		0		1	(0.07)
No Pneumonia--Cough or Cold	915	(38.99)	797	(37.84)	295	(28.28)	432	(30.66)
Pneumonia	53	(2.26)	33	(1.57)	15	(1.44)	16	(1.14)
Skin Disease	97	(4.13)	73	(3.47)	31	(2.97)	28	(1.99)
Typhoid Fever	0		0		0		3	(0.21)
Pelvic Inflammatory Disease	0		0		0		4	(0.28)
Deaths in OPD	1	(0.04)	0		0		0	
<i>Non-Communicable Disease</i>								
Anaemia	22	(0.94)	15	(0.71)	2	(0.19)	7	(0.50)
Asthma	0		0		1	(0.10)	0	
Oral Disease	12	(0.51)	20	(0.95)	12	(1.15)	14	(0.99)
Epilepsy	0		0		2	(0.19)	1	(0.07)
Severe Malnutrition	61	(2.60)	75	(3.56)	1	(0.10)	4	(0.28)
Injuries: Road Traffic Accidents	3	(0.13)	0		3	(0.29)	2	(0.14)
Injuries: Trauma	23	(0.98)	17	(0.81)	55	(5.27)	48	(3.41)
Animal or Snake Bites	0		0		0		2	(0.14)
Other	26	(1.11)	15	(0.71)	49	(4.70)	95	(6.74)

Barriers to Biomedicine

In his analysis of gun-related injuries, Mkutu (2007:40-41) outlined four factors that contribute to the Karimojong's underutilization of biomedicine: mandatory police clearance for all gun-related injuries; cost; precarious travel; and locals' preference for indigenous medicine. Karimojong mothers and healers confirmed Mkutu's findings and elaborated on the barriers of biomedicine. They reported that the current health sector failed them for the following reasons: inadequate medical equipment, supplies, and pharmaceuticals; expensive service and accrued fees, such as "tipping" nurses to ensure good care; and the discriminatory policies of the biomedical establishment that punished users (and practitioners) of indigenous medicine.

Mothers and healers spoke of the tensions between the biomedical community and those who use ethnomedicine. Karimojong mothers rely on indigenous treatments as the sole healthcare strategy when funds are low, as "first-aid" before or en route to the distant biomedical clinics, or after Western medicines have failed. Karimojong mothers repeatedly told stories of nurses slapping patients or outright rejecting treatment if they admitted to using local remedies (Sundal 2008). Because mothers feared retribution, women would try ethnomedicine covertly or delay seeking biomedical care until all signs of the local treatments disappeared. Fear of reprisal discouraged mothers from utilizing biomedicine to its fullest potential and placed children at greater risk. Furthermore, the closed ideology of the biomedical community – that the Karimojong can not benefit from

Western healthcare unless they fully recant their cultural practices – undermined efforts to improve community health.

By instilling the policy that indigenous medicine should be completely abandoned in exchange for Western-based methods, biomedical staff further perpetuate the stereotype that Karimojong ethnomedicine, and thus the Karimojong, are backward. The Karimojong, however, do not reject all biomedicine in favor of local methods. In Moroto District, underutilization of biomedicine does not exist because the Karimojong are unaware of or unwilling to use biomedicine. Karimojong mothers and healers are convinced that biomedicine is effective for certain illnesses. Underutilization exists because the healthcare sector is unwilling to recognize the legitimacy of indigenous healing (Sundal 2008).

Two parallel therapeutic channels now exist in Moroto District – one is legitimized by the state (the sole promotion of biomedicine) whereas the other (indigenous medicine) has been driven underground. The following chapters unpack indigenous healing techniques in an attempt to illuminate the untapped potential of Karimojong ethnomedicine in Moroto District's health sector.

Chapter 6 Nilotic Cosmology, Medicine, and Healers

Pastoralist peoples of East Africa have characteristically a religion whose centre is in the sky, since it is from there that they receive the effects of certain mysterious powers affecting their lives in a positive way (rain, for instance), as well as in a negative one (lightening). The pragmatic mentality of these peoples requires a satisfactory answer about the origin of these happenings, a possibility to control them and, eventually, to manipulate them for their own benefit (Novelli 1999:7)

This chapter explores three core features of Nilotic healing: the association between Nilotic cosmology and indigenous healing; the nosology linked to spiritual origins; and the “call to healing.” These three features are not limited to Nilotic ethnomedicine, but rather are characteristic of African indigenous medicine as a whole (Janzen 1992). Few studies, however, have focused on indigenous healing strategies in Nilotic societies, although there is an extensive literature on the healers’ spiritual and medical practices among Bantu populations (ibid). This chapter situates Karimojong healers within the wider context of Nilotic healing. I review the common features of Nilotic healing, through an examination of the literature on the Nuer agropastoralists of Sudan (Evans-Pritchard 1956, Hutchinson 1996), the Mandari of Sudan (Buxton 1973), the Turkana of Kenya (Little and Leslie 1999, Shell-Duncan, Shelley, and Leslie 1999, Shelley 1985), and the Karimojong of Uganda (Dyson-Hudson 1966, Knighton 2005, Novelli 1988, 1999). Previous studies have centered more specifically on Nilotic religion (Buxton 1973, Evans-Pritchard 1956, Knighton 2005, Novelli 1999), but here I focus more particularly on spiritual

influences on human health and provide a description of how Karimojong may be chosen or are spiritually destined to become healers (i.e., the call to healing).

Nilotic Ethnomedicine

Nilotic ethnomedicine reflects their notions regarding the cosmos, social order, nature, and economic, political, and cultural histories. Common ideologies and praxis among Nilotic healing center on the link between their cosmology and therapeutic strategies. Because local specialists are the primary health providers for many nomadic Nilotic communities, an understanding of their indigenous religious and medical knowledge is beneficial to any healthcare development program. Nilotic healers may be men or women, may focus on one therapy, or may be general practitioners. They may be seers, diviners, herbalists, prophets, or midwives, and they may participate in a variety of healing activities including preparing and administering medicinal plants, divination, interpreting dreams, and consulting spirits (Dyson-Hudson 1966, Novelli 1999). Nilotic healers are not conservative health experts who only rely on so-called traditional approaches, although they are often labeled as such. The term “traditional” places contemporary healers and their practices and knowledge in the past and stigmatizes them as nonadaptive, uneducated, and “primitive” practitioners (Feierman and Janzen 1992, McMillen 2004). Here I characterize healing specialists as “healers” and their therapeutic work as “indigenous medicine.” These terms remove the stigma associated with “traditional” and highlight the reality that local healing is dynamic and subject to outside (non-Nilotic) ideologies.

Changes in Nilotic Healing

Nilotic healers are indeed influenced by outside ideologies and therapeutic systems (both medical and spiritual) in their approach to maintaining and restoring well-being. The introduction of Western-based belief systems – both medical and spiritual – has not only altered the healthcare choices available to pastoralist groups, but has changed healing methods as well. The progressively sedentary lifeways of Nilotic pastoralists have increased their proximity to towns, biomedical healthcare facilities, and Christian missionaries. Nilotic communities have been imbued with biomedical knowledge through a variety of programs, including vaccination campaigns, the training of TBAs, and food relief that is often distributed via biomedical health facilities. For instance, Turkana healing tends to occur within the domain of the family domestic unit, with mothers being the first line of defense against illness. This, however, does not mean that the Turkana do not utilize biomedicine. In 1988, Turkana District had four hospitals, eight health centers, thirty-five dispensaries, and several treatment centers, but because nomadic Turkana had to travel several miles, usually by foot, to access biomedical facilities, the majority of Turkana illnesses were treated at home by immediate family members or with the assistance of a Turkana healer (Shell-Duncan, Shelley, and Leslie 1999).

Hutchinson (1996) examined the impact of Western ideology on the Nuer illness etiology. She explained that the prevalence of nonindigenous diseases (those which can be treated with biomedicine, specifically pharmaceuticals) arose during the 1980s and 1990s. In the early 1980s few biomedical facilities existed in Nuerland,

but by the end of the decade, nearly all villages had “injection specialists,” Nuer who administered intravenous pharmaceuticals. Furthermore, biomedical vernacular – words such as malaria, chloroquine, and penicillin – was pervasive throughout Nuer homesteads and “collective faith in curative powers of imported biomedicines” was strong (Hutchinson 1996:309). Hutchinson also noted that local illness categories have been modified since Evans-Pritchard’s (1956) publication, *Nuer Religion*.

Specifically, diseases the Nuer described as natural or god-induced in the 1950s were explained in the 1980s as being the result of evil medicines, witches, and the supernatural (Hutchinson 1996:306). This new illness etiology changed the therapeutic strategies used by the Nuer as well. Rather than consult a Nuer healer and perform an animal sacrifice, many Nuer instead became Christians. This was a direct result of the influence of Christian missions that indoctrinated locals with biomedical explanations of disease and germ-based etiologies. Furthermore, conversion to Christianity offered educational benefits in addition to medical care.

Christianity has also impacted Karimojong cosmology and healing practices. Knighton (2005, 2007) examined the impact of Western influences – in this case, automatic weapons and Christianity – among the Jie, a member of the Karamojong cluster. He explained that although missionaries (Knighton himself is employed by the Oxford Centre for Missionary Studies) have been present in Karamoja since the early 20th century, they have failed to greatly impact life in Karamoja. Knighton purported that beyond some locals being baptized or utilizing Christian names, Karamojong groups adhered to “their traditional pastoral values” rather than

“enculturating the priorities of modernity” (Knighton 2005:75, Mkutu 2005). This view fails to recognize the Western influences on Karimojong approaches to healthcare and illness classification, which Karimojong informants acknowledged throughout our interview sessions. For example, one Karimojong healer modified her therapeutic technique in accordance with the Christian teachings at her church.

She explained:

The spirits showed me how to kill sacrifices for sick people. But, some years ago when I was baptized the priest told me to bring all the strings [strips of hide from a sacrificed animal that are worn on the patient’s body] to the church because sacrificing animals was devil’s work. I stopped doing the sacrifices but I still know the herbs (MP73 4/26/07).

Another healer, Lotukei, had similar experiences when incorporating Christian beliefs into her indigenous healing practices. Lotukei had contemplated abandoning her indigenous healing work altogether in favor of becoming a saved Christian. She explained that her daughter became active in the local church and started a prayer group to alleviate Lotukei’s sickness.

Whenever it is cloudy I have bad headaches. I want to be a staunch Christian so I’ll be rid of my healing spirits. Since I was initiated as a healer I have not had a single good harvest, but before then I always had something in my granary. An angel told me that because I accepted the healing spirits I should suffer. So now it is the devil and Jesus who are fighting for my body. Jesus came to me and said “look at those enemies; they are the people who killed me.” To have eternal life I must get rid of those spirits, otherwise I will suffer with bad harvests and continual sickness (AP15 5/29/07).

Lotukei’s quote exemplifies how Christianity has influenced both Karimojong cosmos and related healing ideologies. She used English words, such as Jesus and devil, and Christian concepts of eternal life to explain her physical illness as the

battle between the Christian deity (Jesus) and the Karimojong spirits (the spirits that made her a healer). Furthermore, Lotukei stated that the appropriate treatment for her illness was not the consultation with her healing spirits (or another healer's) but rather salvation as defined by the Catholic Church.

The Nilotic Cosmos

Nilotic cosmology is a reflection of their social order (Evans-Pritchard 1956) and although it should never be viewed as a fixed or homogenous system, commonalities of cosmological beliefs exist among different Nilotic groups. First, all Nilotic societies have a belief in a human creator or a divinity (Buxton 1973, Dyson-Hudson 1966, Evans-Pritchard 1956, Knighton 2005, Novelli 1999). Evans-Pritchard (1956) described the Nuer divinity as the Spirit of the Sky and Buxton (1973:17) described the Mandari divinity, *Nun*, as the creator of humans and the universe. The Turkana and the Karimojong recognize *Akuj* as their divinity. In NgaKarimojong, the word *Akuj* means both sky and deity; similarly the word *Kuju* may be translated as north or overhead (Novelli 1987, 1999:10). *Akuj* controls nature, offers people (individually or collectively) assistance, and communicates to humans through dreams and prophetic visions or through other Karimojong who have been chosen to become healers (Dyson-Hudson 1966:212-213).

In general, Nilotic societies contact the supernatural through prayers to the deity; through sacrifices, gifts, and respectful behavior to appease the spirits; and mediation by Karimojong healers (Novelli 1999:41). Nilotic healers function as the bridge between the supernatural and humans because they have the ability to

communicate directly to the divine on behalf of those in need. According to a Karimojong healer, “Akuj decides who will be an *emuron*” (APM1 3/17/07).²¹

Second, Nilotic pastoralists link their divinity to the sacredness of their cattle. “To approach the deity for assistance in a public context requires that one or more oxen of propitious characteristics be speared. The intestines of the animal are examined by a *haruspex* [soothsayer] to forecast the shape of future events” (Dyson-Hudson 1966:95). I attended a divination ceremony at village AP where the male elders petitioned Akuj to bring rain and halt future enemy attacks (this ceremony occurred after the two cattle raids discussed in Chapter 3). At the ceremony, 19 men were seated in a semicircle in front of a slain calf.²² A man began the ceremony with the opening salutation, “Akuj listen to our pleas. We ask for rain and sorghum. What is in my heart is for the sacrifice to be successful.” The sacrifice (the calf) had been slaughtered, partially dismembered, and its intestines “read” by *ngimurok* (male healers) prior to my arrival at the ceremony. After the opening prayer, young men roasted portions of the sacrifice, such as the hind limbs, on an open fire and distributed the meat according to participants’ generation and age sets. A diviner-healer spoke “I have read [the calf’s intestines] that the harvest will be abundant. But, animal diseases and enemies will also come. Something—either enemies or armies—are coming from the southwest.” The sacrificed calf functioned as the medium through which the Karimojong and Akuj communicated. Akuj first

²¹ In NgaKarimojong the term *emuron* refers to a male local healer (*ngimurok* is the plural form), whereas *amuron* (*ngamurok*, plural) is a female healer (Novelli 1999).

²² This was a men’s ritual; thus, it was a special privilege that Akol and I were invited to attend and seated directly next to the men’s senior generation set. This may have been influenced by the arrival of my husband a week prior, who also attended the ceremony.

informed the healers of future events through messages displayed in the calf's intestines. Certain healers (identified as *ngimurok ngulu isyoman ngamoliteny*, healers who can read animal entrails to divine events) have the skill to examine sacrificed animals' intestines. The Karimojong then present the sacrificed animal as a gift to Akuj so that their requests (in this instance rain and sorghum) will be granted. The sacrificed animal embodies the communication between the divine and the secular. First, the deity relays messages pertaining to future events within the entrails and it is the healers who read and interpret them. Second, humans petition the deity to mitigate harmful effects by sacrificing the animal for the deity. Third, Nilotic cosmology recognizes the manifestations of the divinity as spirits. These spirits are the avenue through which social mores are enforced. Previous scholars of Nilotic religion (Buxton 1973, Evans-Pritchard 1956) found that Nilotic spirits broadly fall within two categories: the divine spirits (or above spirits) and ancestor spirits (or below spirits). These spirits intervene directly in Nilotic societies, both by expressing their wishes through healers and by afflicting people with illnesses if they have been wronged.

Spiritual Influences on Human Health

Violating social norms, taboos, and respect rules have serious health consequences for Nilotic individuals and communities. Offending the spirits of the Nilotic cosmos can alter collective human and livestock health and well-being. A sinner's entire family must immediately atone for that sin (the greater the sin the larger the atonement). The exoneration for sin thus goes beyond the Western

religious notion of personal penance; without collective atonement entire communities are at risk of serious illness or even death. This is because Nilotic spirits, both ancestral and divine, have the ability to cause illness to the kin of a person who committed a taboo act. The offending family may seek assistance from a healer to ascertain the proper rituals for atonement. Healers consult the spirits and then advise sinners on how they can restore community and individual health through indemnification. It is through this process – sin, illness, healer consultation, spiritual guidance, atonement, and finally the restoration of health – that healers serve as a bridge between the cosmos and the living. Nilotic healers are central to Nilotic cosmology because they function as the intermediaries between humans and the divine. Healers thus fulfill various roles within their communities through the treatment and prevention of illness, the maintenance of spiritual well-being, the prediction of impending attacks, and the blessing of raids.

Among the Nuer, ancestral spirits impact the health and well-being of their living descendants. These spirits can cause illness if their living descendants who do not perform rituals properly or if they break Nuer social norms (Evans-Pritchard 1956:128-134). For example, when one marries, the groom's age mates give an ox for sacrifice. This ox is dedicated to the bride's ancestors to beg them for healthy offspring for the newly married couple. If the ox is not sacrificed and the woman's ancestors not properly acknowledged, the offended ancestor spirits display their anger by causing harm to future offspring (Evans-Pritchard 1956). Female ancestral spirits also have direct control on their descendants' fertility according to Mandari

beliefs. If a Mandari ancestral spirit is not properly acknowledged through gifts and rituals, this female spirit can make her female descendants infertile. To appease wronged ancestors the Mandari must perform rituals, such as beer libations and ox sacrifices (Buxton 1973), which mitigate any health consequences of the offense.

Nilotic divinity spirits may also cause illness. A particular Mandari spirit (*mayom*) causes one's body to swell. Treatment for this Mandari illness – as directed by a Mandari healer – includes the sacrifice of an ox and bodily incisions treated with an herbal mixture. One group of divine spirits (“major” spirits) affects the Mandari's mental clarity. Because weather events, such as rainfall, often begin and end quickly and occur in the sky where the air spirits are believed to reside, the Mandari link the sudden onset of mental illnesses, which follows a similar pattern (i.e., thunder may strike suddenly like a mental attack may strike without warning) to air spirits. Epilepsy occurs when Mandari come into contact with the divine spirits during the moon's waxing and waning periods (Buxton 1973).

Like the Nuer and the Mandari, the Karimojong also attribute illness and death to affronts to the divinity or the spirits. This can occur when ancestral spirits have been angered, when rites or rituals are performed improperly, or when someone has practiced sorcery. Karimojong ancestral spirits can cause harm or sickness to those people who wronged them. One example that exemplifies the link between the ancestors and the living is the Karimojong adherence to twin rituals even when one or both of the twin pair have died. The Karimojong consider twins to be a blessing; thus, special ceremonies and rituals are performed to honor twins.

Two informants (AP43 and AP98) who had twins linked the special status of twins to the difficulty posed to the mother during pregnancy and to the fact that Akuj put two babies in the womb rather than one. Any Karimojong who has borne twins must perform three sets of rituals yearly, which correspond to the agricultural cycle, to acknowledge the special status of the twins: at the beginning of the planting season; during threshing to taste their new food; and the final ritual to bless the harvest season. Seven women in the sample of mothers in this study had twins (one of these women had three sets and another had two sets). All seven mothers discussed the difficulty in carrying out the three twin rituals due to the amount of food and monetary resources each ritual required. Three of the mothers had lost at least one twin, but all still performed the twin rituals because, if they did not, the deceased twin could cause havoc to the living. One mother, who lost both twins (the first was stillborn and the other child died when she was approximately two years old) explained that although neither twin was alive, she still had to perform the rituals yearly.

I have to continue because if I don't, the twins, although dead, can make my gardens not produce. I have to keep the twins' spirits happy. The twins can also affect my livestock and can close my womb, making me infertile. I fear that my womb will get locked (AP98 3/2/07).

Her husband confirmed her fears and explained that they perform the rituals to receive the twins' blessing, but if they stopped the rituals their deceased twins would be deeply offended. When I asked what specifically could happen if they skipped the rituals, the mother said "I wouldn't conceive again due to sickness from

the twins. Our animals wouldn't multiply, and we would not get anything the next harvest."

Karimojong ancestor spirits can cause great harm to the living and influence well-being. If one has been struck with a spiritual illness, a Karimojong healer will advise the family of the afflicted to make appeasements to the spirits (Novelli 1999). This occurs for both ancestral spirits, as illustrated in the twin example above, and for divinity spirits, which typically reside in trees and bodies of water. One particular illness (*ekuwam*) occurs when a Karimojong disrupts the homes of the spirits. Disrupting the spirits' habitat is the impetus that causes one to become ill with *ekuwam*. A Karimojong mother explained,

Sometimes a person can step on a spirit when she goes to collect water from the dam. Or when someone walks along the river and forgets to cough to signal her approach, she'll get sick because the spirit is annoyed that it wasn't warned. Even this borehole here is thought to have spirits; you must bang your jerry cans together to warn the spirits you are coming (KK167 5/3/07).

A healer described the etiology of *ekuwam*: "a tree can become a home of the spirits and when a person cuts the tree, the spirits get annoyed and make that person sick" (KK139 3/11/07). Symptoms of *ekuwam* include severe diarrhea, madness, and rapid weight loss. According to Karimojong informants, *ekuwam* is resistant to biomedicine; informants were adamant that biomedicine was an ineffective treatment and that only indigenous methods could restore well-being of the afflicted. Local treatments for *ekuwam* include a healer sacrificing an animal at the location where the offender crossed the river or cut a tree down. The afflicted also consume an herbal mixture usually served in a stew (made with the sacrificed animal's meat)

and have their body smeared with red, green, and blue colored clay in a striped fashion.

A Karimojong woman, Iriama, described her struggle with ekuwam and the treatment method in detail (AP22 3/13/07). She had fallen ill after a day of gathering firewood with her eldest co-wife. They had traveled far and when they reached the riverbed, her co-wife showed her that the river was actually a watering hole. When Iriama looked into the hole, she upset the spirits who took their revenge by making her extremely ill.

When I came home after collecting firewood I started shivering. At night I had diarrhea, so bad that it just flowed out by itself. As I was getting sick I could hear a voice saying “why did you peep at me today?” After this I became very thin, so I told my people what had happened. An emuron took my co-wife and I back to the riverbed where we showed him the spot I had peeped in. The emuron smeared blue, green, and red clay all over my body. Then the emuron took an herb, dipped it in water, and sprinkled my head. Some power made me suddenly turn around, but then I fell, vomited, and had more diarrhea (AP22 3/13/07).

Iriama’s initial treatment, however, failed to relieve all of her symptoms and her brother came to care for her. When he arrived he immediately confirmed that Iriama had ekuwam and took her to a second healer. The second healer sacrificed a brown goat, smeared Iriama with its blood, tied strings of the goat’s hide to her body, and served her stew made from the goat’s meat. Iriama reported that the initial healer’s work was insufficient because it lacked a sacrifice, but that after visiting the second healer she was cured of ekuwam (AP22 3/13/07).

Ekuwam results when Karimojong disturb spirits that inhabit precious resources for the Karimojong: trees and water. Both trees and water are scarce and

extremely valuable (e.g., trees provide needed shelter from the harsh sun). Trees increasingly are being cut down to make charcoal which can be sold or exchanged for other goods, whereas water sources are heavily contested among herders. Ekuwam then may be viewed as an indigenous measure that affirms cultural value in resources. The treatment for ekuwam confirms this theory. Karimojong consider biomedicine useless in treating the symptoms. Only a petition to the spirits through an animal sacrifice and smearing of particular clays mediated by a healer can cure this illness. Healers are the intermediary between the afflicted person and the offended spirit that caused the illness and have the ability to restore harmony, thus restoring the afflicted to good health.

Amuronot: The Call to Healing

Common among Nilotic healers is their path to becoming “one who treats.” The majority of Nilotic healers are first themselves afflicted with a divine illness (the call to healing). The call to healing is a rite of passage: “chosen” individuals become very ill; they abruptly separate themselves from others; they recognize the cause of their illness as a call to healing and are treated by a healer; they return to a healthy state; and they begin practicing as a healer. The call to healing is not exclusively a Nilotic institution: it has been reported for several African societies (see Janzen 1992, Yahaya, Aryeija, and Bitwari 2004). In his book *Ngoma: Discourses of Healing in Central and Southern Africa*, Janzen (1992) described ngoma as a “ritual therapeutic institution” that is widespread across the Bantu regions of sub-Saharan Africa. Janzen stated that as a cult of affliction, ngoma is based on a core set of features.

Some of these features resemble the Nilotic call to healing. For instance, ngoma healers first suffer some form of illness and undergo a therapeutic initiation. Another common feature between Ngoma and Nilotic healing is the classification of spirit-induced illnesses. Here, I elaborate on the Nilotic call to healing.

Mandari healers receive their religious call to healing when they first experience psychological and/or physical disturbances. Typically the afflicted individual separates herself from others; she may wander off to the bush or refuse all communication and food. If the chosen Mandari recovers from her illness and becomes a healer, she must then raise a shrine honoring the Mandari celestial spirits (Buxton 1973:291). The Nuer's path to healing follows the same trend. A chosen Nuer is possessed by the celestial spirits (either permanently or temporarily). An individual afflicted with a celestial illness may be cured by a Nuer healer, who is able to divine the illness as well as cure it; the possession of the celestial spirit then is temporary. However, if the symptoms worsen, possession may be permanent, which signifies that the spirits have chosen this Nuer individual to become a healer as well.

Karimojong Paths to Healing

Novelli (1999:108-110) described three paths by which Karimojong may become healers: a person may simply decide to do so as a mode of employment or skill; the position may be hereditary; or an individual may be "called" by spirits. The Karimojong healers I interviewed discussed similar avenues for becoming indigenous healing practitioners. Informants relayed detailed information on the

process of becoming a healer, including their familial connections to healing; what symptoms indicated that they were destined to become a healer; how they resolved these symptoms; and their process of initiation (or not).

Eight Karimojong healers stated that they had not undergone an official rite of passage or initiation to become healers, but had become healers of their own volition.²³ These uninitiated healers chose this work because they believed they possessed an inherent ability to help others or found healing a worthy economic pursuit. Three men reported that they knew they were Karimojong healers because when they were young they foretold future events and developed reputations as soothsayers. None of these three men had undergone an initiation ritual. The uninitiated women's responses were more varied as to the reasons they became healers: some reported that their healing capabilities were god-given talents, whereas others stated they had received training from practicing healers but were never initiated themselves. The commonality among uninitiated women, however, was that they were all specialists who practiced one particular health therapy, such as removing children's "false teeth" or administering herbal remedies. None of these women were soothsayers (see Table 7.1) who consulted Karimojong divinity spirits as part of their healing repertoire.

Nearly all Karimojong healers reported that their work was hereditary. Seven male healers and twelve female healers acknowledged they had at least one other family member who was also a healer, whereas only four women responded

²³ One healer (MP68) is excluded from the initiation analysis. This informant did not provide any demographic data or information pertaining to how she became a healer. I interviewed this woman because she was the apprentice of another healer (MP73).

they were the sole healers in their families. Among the 19 informants who identified other healers among their relatives, I did not find a connection between the informants' sex and the sex of the other healers in their families. Rather, Karimojong men and women reported that healers could be found among both their patriline and matriline (thus, male healers did not have only other male healers in their families).

Finally, 19 healers (not all the same as above) underwent an official initiation to become a Karimojong healer.²⁴ Of the initiated healers, three did not have other healers in their families, and one did not indicate her familial status. The initiated healers described the various ways they knew they were chosen to become healers. The Karimojong call to healing is a recognition – by the afflicted and the larger community in which they reside – that the “chosen” have intuitive connections with the divine. Importantly, the call to healing has physical symptoms. Chosen individuals may experience some form of illness, either mental or physical, undergo a period when they are removed from their community, behave in an abnormal manner (for example, climbing trees and jumping into bodies of water), or have prophetic dreams and visions. Novelli (1999:110) explained “that since something strange has happened to them, or better, somebody mysterious has taken possession of them, it becomes manifest that they are in contact with powers of the other world.” Informants described the physical manifestation of the call to healing with

²⁴ One of these 19 informants is a woman waiting to hold her initiation – at the time of the interview she did not have enough resources for the initiation ceremony. I include her here because she planned to become initiated. The remaining eight healers in the sample were never initiated and were not planning to do so.

one inclusive term *amuronot*.²⁵ Healers spoke of instances in which amuronot caused them to act in bizarre and uncharacteristic ways. General themes included disappearing for days, climbing trees, running widely, jumping on roofs or over fences, walking naked, and speaking nonsensically.

An ethnographic account of a teenage girl who is destined to become a healer is presented here. The girl's story illustrates the Karimojong call to healing and describes the physical and mental impacts of amuronot. The call to healing does not go unnoticed. It is linked to the Karimojong cosmos and is expressed by a traumatic event that can extend across many years and places a great burden (and expense) on the afflicted and her family. I use this example to illuminate the common features of amuronot and its resolution.

Aleper: A Chosen Karimojong girl

I first met the 16-year old Bokora girl, Aleper, the day she returned home after three months spent begging on the streets of Kampala. I was interviewing her mother as she walked into the compound. Her mother jumped up, hugged the girl, and called her siblings into the yard. Five hours into our first meeting Aleper's mother began to describe the girl's previous illnesses. I soon learned that Aleper was one of those chosen to become an amuron. Her mother recalled:

Aleper was sick with a disease that made her look like she was mentally disturbed. Aleper would even jump on the roof. An amuron came and said that Aleper could become an amuron herself so the gourd [a healing instrument] was brought to us. They killed a black he-goat to suppress Aleper's spirits until she can grow up. This

²⁵ The Verona Fathers (1986) translate amuronot as witchcraft or sacrifice in their NgaKarimojong-English dictionary; however, Karimojong informants repeatedly used this term to describe the process by which one recognizes she is a healer (amuron).

was in the 2006 planting season, but the amuronot first started in the 2005 planting season. Girls were beating and playing a homemade drum, and then Aleper had a fit and became unconscious. *Ngamurok* [female healers] came singing and shaking their gourds. Aleper then came back to her senses. When she grows older we will do another ritual to complete her initiation to become an amuron. On the day of the final ritual we will kill another black he-goat [on which] we will sew dark blue beads and cowrie shells onto the skin; Aleper will receive the goat skin. We can't do the ritual now because it is expensive—it needs a lot of beer because the ngamurok will drink all night (AP22 2/22/07).

Aleper's mother next explained that amuronot runs in her family lineage. Aleper's maternal grandmother was afflicted with amuronot but refused to become a healer. Rejecting the call to healing made the grandmother severely ill and caused her to go blind. In addition, two of Aleper's maternal aunts and their daughters (four total) are practicing ngamurok. Aleper's mother, however, is not a healer and never suffered from amuronot.

During a subsequent interview, Aleper's mother reported that her daughter had fallen sick again. Five days previously, villagers held a dance with singing and drumming lasting into the night. The rhythmic beats stimulated Aleper to again convulse and faint. The following day she complained of *etau* (heart pain) for which her mother gave her the *lojokio*²⁶ herb obtained from an amuron. As Aleper's mother explained, *lojokio* is an effective treatment for *etau* because "that herb is the one which relieves a person from spirits. When a person recovers, the spirits still hold to her heart so this herb helps to release her" (AP22 3/13/07). Each time Aleper

²⁶ In NgaKarimojong, *lojokio* is derived from the word *ngijokia* which can be translated as "spirits."

experienced convulsions and etau her mother gave her the herbal remedy. Aleper described her affliction (AP22 3/13/07):

Aleper: I get dizzy and everything turns black. As soon as I hear drumming, it is as if the drumming is coming from my heart. I don't know how many times, but it started in 2005. After the drumming begins I find my body very tight. When I recover I am really thirsty. Sometimes even without fainting I can feel etau, which is constant and severe.

MBS: How do you make etau go away?

Aleper: *Lojokio* only.

MBS: Do you have any other frequent illnesses?

Aleper: Nothing else. My sicknesses are always from the head and the heart.

MBS: What causes that sickness?

Aleper: I don't know. I feel that it should be from Akuj.

MBS: Your mother said there was a ritual to suppress amuronot here. Who was that for?

Aleper: I'm the one.

MBS: What happens to you later?

Aleper: I don't know.

Her mother: Don't you know you will be initiated? You'll be made into an amuron when there is a good harvest.

Aleper: I am looking to it so the heart pain will stop.

During interviews, other informants recalled stories similar to Aleper's experience. Healers spoke of moments of confusion where they either fainted (usually in response to the beating of a drum) or ran about in a maddened state,

suffered additional physical illnesses (such as heart pain), were diagnosed with amuronot, and suppressed their initiation until they were old enough to become healers themselves.

Expressions of Amuronot

In fact, nine of the Karimojong healers (all women) who reported they were afflicted with amuronot identified themselves as suffering from some form of madness or mental illness. One healer said her family first realized she had the call to heal because she was ill. "I had a severe headache and became crazy and mad. I talked to myself and people feared me because I was mad. The emuron said it was not [physical] sickness but amuronot and if my family didn't do the ritual it would get worse" (AP43 5/4/07). A second woman's experiences echoed the first healer's. She explained that her amuronot struck her after her husband died and caused her mental confusion. "I would just run aimlessly. The spirits would make me grab people and yell at them for being in my garden even though it was the dry season and there was no sorghum to be found" (MT2 6/23/07). Karimojong informants explained that madness was a typical expression of amuronot and that the only way one could return to a normal state was to acknowledge the Karimojong spirits, thus becoming a healer too.

A second theme among many healers (five women and two men) was a period of time in which they were removed from their families and lived with the spirits underwater or in the trees. Dyson-Hudson (1966:213) explained that the Karimojong spirits' "closest contact with the material world is descent to the topmost

branches of high trees.” According to one healer, “I became mentally disturbed and started climbing on top of trees. One time I climbed a tree and refused to get down until a black he-goat was killed; then I got down from the tree” (MT4 6/29/07).

Another healer also reported that her amuronot began when she was taken from her family as a young girl. The “amuronot spirit would make me want to go to the water or hold onto a tree for hours and hours until the madness left and then I could leave the tree” (AP15 5-29-07). A third healer recounted “when I was a baby there was one night the spirits took me from my mother’s breast and returned me at cock crow. Then, when I was about seven years old I used to disappear to the mountains and rivers” (AP1495/30/07). Thus, amuronot causes healers to suffer a period of mental instability as well as to seek refuge in the domain of the Karimojong spirits. The liminal period endured by chosen Karimojong – a time when they were taken from their human families to reside with the spirits – was part of their expression of amuronot.

A few of the healers whose amuronot caused them to live underwater were also initiated as an official healer by the spirits themselves. For example, one male healer (a renowned soothsayer) explained that an elder Karimojong healer did not initiate him – which is typical for most initiations – but that the underwater spirits did.

The spirits of amuronot got into me when I was a small child. There was famine and my mother had gone to Jie for casual labor. One night I was at my mother’s breast but the spirits removed me and took me to the river. [In the river] I was told that when I grew up I should bless warriors going on a raid, smear people with clay, and foretell events. I was also given the power to use sandals [for

divination]. The spirits were the ones who initiated me during the three weeks I was missing. My relatives had mourned because they thought they wouldn't see me again. The spirits killed a black he-goat, tied the skins, and put cowrie shells on it. One night when my mother was asleep, the spirits took me back to her breast. She found me there with the string and cowrie shells. Since that time I was an emuron (APM2 6/6/07).

Another healer reported a similar experience (KK178 6/1/07). As a child the spirits told her to run to the river one evening after supper. Her family followed after her, but she was too quick. She jumped into the river and was not seen again for four days. Underwater the spirits initiated her as a healer. Unlike the man above, however, it was the woman's father who sacrificed a black he-goat at the river's edge. The spirits pulled the goat underwater, skinned it, attached cowrie shells to it, and gave it to the child as a symbol of her initiation. A male healer also explained how the spirits initiated him:

When I was a young man in 1978, one day I was playing with other children in a pool of water. We would jump into the water. Others came out of the water, but I stayed in. After three days my brother took a goat to the water, killed it, and smeared the chyme and then I came out of the water. It was a black he-goat that made the spirits not kill me. In the water a white girl was putting on cowrie shells—these are the cowrie shells on my necklace—called to me to be her husband. I was in a big home with a lot of cattle. When I came out of the water I was not even wet and I was naked. I went back to my parents' homestead and that night I found my [divination] sandals by my head (MPM1 7/5/07).

These healers explained that the spirits initiated them or taught them Karimojong indigenous medicine. When they were returned home their community recognized them as legitimate healers. The healers' amuronot was expressed by the fact that they had gone missing when they were children.

Amuronot and Fertility

For ngamurok, amuronot affects fertility but does so according to one's stage in life: adult women become initiated healers to cure infertility, but pubescent girls delay their initiation to protect their potential fertility. In adult women amuronot may be expressed through reproductive failures such as infertility, miscarriages, and successive deaths of offspring; adult women may undergo the healer initiation as a means to restore their fertility. Women's infertility may occur in conjunction with episodes of madness or as the sole signifier that the afflicted has been chosen to become a healer. This is not to say that all Karimojong women who are barren or undergo reproductive challenges are destined to become healers; nor is it the case that all adult Karimojong who recognize their call to healing escaped amuronot symptoms as children. These reproductively challenged women were the embodiment of social suffering within Karimojong communities and as such were diagnosed as being afflicted with amuronot after successive pregnancy failures.

One Karimojong woman, who suffered two miscarriages and lost three other children, affirmed that she was an herbal apprentice. Although she was diagnosed as suffering amuronot, she had not undergone the official initiation ritual due to its associated expense. She stated, "After my last miscarriage an amuron said it was caused by amuronot and it would be better if a he-goat was sacrificed to suppress the spirits. The ceremony would have been done, but all our animals got raided off, so the ritual will be done later" (AP41 3/13/07). This woman's explanation

underscores how cattle raiding is also a barrier to spiritual healing because her family was unable to perform the amuronot ritual after their animals were stolen.

An elder healer who never bore children stated that she became a healer because of her barrenness. "It happened when I was still a young woman trying to do everything. I was trying to get pregnant but the amuron thought it was amuronot keeping me from getting pregnant so I was initiated as one also" (MT4 6/29/07). Soon after her initiation, however, her husband died and this healer resolved never to remarry. She then moved from her rural village to Moroto Town where she established herself as a practicing healer. For adult Karimojong women the inability to reproduce or produce larger families is considered a social illness, one explanation of which is amuronot. Again, a diagnosis of amuronot, versus some other illness, can only be divined by a Karimojong healer.

Whereas adult women were initiated as healers to restore their fertility, young women delayed their initiation to protect their fertility. Six female healers in this sample reported at least one suppression ritual. Karimojong healers explained that one should suppress the amuronot if she is still young and in prime reproductive years, otherwise the power of being a healer, dealing with sick patients, and consulting spirits for cures was a potential risk to her own fertility. Rituals are therefore performed to suppress the amuronot or to appease the spirits until adulthood (as exemplified by Aleper's experience). One healer underwent the suppression ritual on three separate occasions during childhood. Her family finally deduced that her continual illnesses were the result of a very strong amuronot, one

that could no longer be suppressed. When this woman was approximately 19 years of age, she underwent the initiation to become a healer. “I was initiated completely but I was not happy because I feared that I wouldn’t produce children. I was told that when a young girl becomes a healer she might become infertile. That is why I think I lost so many pregnancies” (AP149 5/30/07).

Another woman, Akol, tearfully described the dangers of angering the amuronot spirits. Akol had suppressed the amuronot spirit several times as an adult because she had not wanted to work as a healer. The spirits, however, were persistent – Akol became very ill and was unable to care for her children, so her family had her officially initiated as a healer.

The spirits had again come into my head and talked to me. After the suppression ritual the fainting stopped completely. This was after I had produced seven children. When spirits started attacking me again, I had conceived my eighth child and gave birth well. But, one night the spirits came to my head and I put the baby into the fire (AP142 3/20/07).

Later in the conversation, Akol explained why the spirits caused her to throw the baby into the fire. Several years before her eighth child died, Akol was initiated as a healer. Her healing tools included a gourd which housed her divination spirits. A house fire, however, destroyed her gourd, burning the spirits inside. Akol remarked that the spirits retaliated by “pushing” her baby into the fire. After the baby died, Akol underwent a second initiation ritual with a different healer to appease the spirits and to resume her healing work again. From that point on, she no longer suffered madness attacks.

Healer Initiation: *Akitmuroiyar* (*akitumu roiyor*)

To correctly interpret the spirits' wishes, a healer must diagnose amuronot for the afflicted. This healer will provide the details of the amuronot, how one can suppress it (if desired), and/or the steps required to fully relieve associated illnesses. To become officially initiated as a Karimojong healer, one must undergo a specific ritual, *akitmuroiyar*. This ritual is similar to the Nuer initiation ritual in which the afflicted clan family sacrifices a bearded, black animal (often a goat). The goat's hide is prepared for the initiated to wear and signifies that he has become a healer. The newly initiated Nuer emuron will wear the animal's skin and ties its tail around his forehead to protect him from headaches and heart palpitations linked to spiritual possession (Evans-Pritchard 1956).

For the Karimojong, *akitmuroiyar* occurs during a feast where the amuronot spirits of a practicing healer are recognized as being the same as those affecting the afflicted. At the celebration, the family of the afflicted must provide enough food and beer to nourish the participants (relatives and many healers) through an evening of dancing and drumming. The family must serve sorghum atap with multiple sauces, locally brewed sorghum beer, and the meat of the sacrificed black he-goat. Pieces of the goat's hide are decorated with cowrie shells, while others are cut in strips and tied on the newly initiated healer. Karimojong healing instruments can either be given at the ritual – in this case it is usually giraffe-hide sandals or a dried gourd, both for divination – or be made by the healer herself (e.g., a healer may use an old pot to “bury” evil eye removed from patients or a sharpened nail to remove

children's false teeth as discussed in the following chapter). An excerpt from an interview with a Karimojong healer regarding her initiation provides the general details of the event:

My husband got a black he-goat and contributed 20,000 shillings for the ritual. We gave the money as an offering to the spirits of the amuron the day the amuron killed the goat. The amuron consulted her own spirits and found out that my amuronot were harsh spirits from Teso lake. I was told to get groundnuts, sesame seeds, salt, sweet potatoes, ghee, cowpeas, cucumbers, cow's blood, and sorghum flour. We cooked the atap by combining the sorghum flour with the cow's blood and cowpeas. Then it was served in many portions in calabashes and wooden dishes. The groundnut paste with sesame sauce was mixed with salt and served in other dishes. The pounded cucumber seeds were added to atap with ghee on all dishes. I was the one to present the food to everyone to eat, but because I was crazy, I had to be led to each person. We added the goat's meat to a soup and served it with atap. The goat's chyme was put on my head and then covered with the fat from the goat's intestines. Next, the goat's stomach was put over the intestines – all on my head.

So, people ate and then dispersed. At dusk, they started the drumming of *abul* – much water was put in a large basin and the calabash put upside down over the water to make a drum. I jumped and played so much and even jumped on roofs and slid down. As there were many ngamurok and one emuron, many dropped down unconscious like I did due to the drum beating. We all then fell asleep. The next day the ngamurok brought me two gourds they had prepared for me – they put a yellow band on the one which contained the female spirit and a red band on the gourd with the male spirit in it. The ngamurok then showed me how to converse with the spirits. When I did it, the spirits spoke. Another amuron showed me how to remove evil eye and how to prepare the *abukut* [softened sisal used to remove the evil eye]. They then took me to the bush and showed me different herbs and told me what they are used for. Under each plant I had to drop a coin or a bracelet (AP43 5/4/07).

Her story exemplifies a "typical" Karimojong healing initiative. Healers spoke of essential items for the initiation. First, a black he-goat is slaughtered to appease the spirits and to request release of the afflicted from her symptoms and her recognition

as a true healer; the initiated wear the decorated hide as a symbol of their status and initiation. Second, specific ingredients (nuts, seeds, and fat) are used to make “rich” sauces for the main staple food (atap) while large quantities of sorghum are needed to brew the local beer. These ingredients for the sauces signify plentiful harvest or wealth; many Karimojong lack these items, especially during drought years, which may be one reason to delay initiation. Third, numerous healers attend the initiation ceremony, but only one or two healers are in charge of initiating the new healer. During the ceremony there is drumming and dancing and the healers experience moments in which they run around madly and/or faint, actions associated with being afflicted with amuronot.

Karimojong not only sacrifice black he-goats for the initiation ritual but also to suppress the amuronot until a more propitious time for initiation. During the latter, the sacrifice functions as an appeasement to the spirits. The afflicted’s family ask the sprits to alleviate the symptoms for a period of time. The suppression ritual is like akitmuroiyar with similar foods prepared, but smaller in scale and significance because the afflicted will still need to be initiated.

Conclusion

Nilotic ethnomedicine maintains and restores individual and community health and well-being. Although, indigenous healing practices vary among Nilotic populations, in this chapter I emphasized shared characteristics. First, Nilotic cosmology, and therefore healing, responds to potential and realized dangers to both human and livestock well-being. Nilotic healers function as a medium through

which the divinity communicates with the human population. Nilotic societies recognize two broad categories of spirits — those of ancestral and of divine origin. Second, Nilotic ancestral and divinity spirits have direct impact on the living in their ability to inflict harm or to offer blessings. The consultation with Nilotic healers is the historic resolution to spiritually defined illnesses. Healers contact the spirits on behalf of their patients. It is the healers' connection to the supernatural that enables them to heal bodily afflictions, address past wrong doings, and restore social order. Finally, as practitioners of indigenous medicine and as a consequence of having been "chosen" by the divine, healers hold a special role in Nilotic societies.

Chapter 7 Karimojong Indigenous Medicine

Both pharmaceuticals and medicinal plants are good medicines. In fact, Karimojong healers are just like doctors, they both cure sicknesses (KK139 5/8/07).

This chapter defines Karimojong perceptions of sickness, health, and healing methods. Researchers (Buxton 1973, Evans-Pritchard 1956, Knighton 2005, Shell-Duncan, Shelley, and Leslie 1999, Shelley 1985) have examined Nilotic cosmology and its connections to illness and health, but here I extend the analysis beyond the spiritual realm to illuminate the medical aspects of Karimojong healing. In Karamoja, ethnomedical healing goes far beyond indigenous cosmological beliefs and is a varied repertoire of therapy strategies that includes biomedicine as well as indigenous medicine. Beginning with an outline of how indigenous medicine is utilized in Uganda, this chapter examines what Karimojong indigenous medicine is, who are its users, and who are the practitioners. Not only are mothers the primary decision makers regarding healing treatment measures, they are also healthcare providers themselves. Furthermore, healers' skills fall along a continuum: healers may have specific technical trades (such as removing false teeth) or may be multitiered health practitioners who have the ability to communicate with Karimojong spirits.

Indigenous Medicine in Uganda

Despite the fact that 60% of Ugandans rely on indigenous medicine as their primary healthcare strategy, Ugandan health policies do not adequately account for this practice. The MoH does not regulate herbal medicines, does not have

institutions in place to carry out research on local medicines, and lacks a budget, training, or infrastructure for including indigenous medicine in the national healthcare system (WHO 2002). In the report, *WHO Traditional Medicine Strategy 2002-2005* (2002), healthcare systems are ranked according to their incorporation of indigenous medicine into the health sector: (1) integrative systems in which complementary alternative medicine and local medicines are fully incorporated into the national healthcare system and indigenous products are registered and available in biomedical clinics; (2) inclusive systems where local medicines are officially recognized but not completely integrated and have little regulation; and (3) tolerant systems where the healthcare system is based exclusively on biomedicine with only a slight acceptance of indigenous medicines. Uganda's policies are only "tolerant" of indigenous medicine.

Uganda is ranked as a tolerant system because its policies demonize and devalue indigenous practices, including local medicine. Colonial and postcolonial administrations attempted to replace indigenous medicine with biomedicine in an effort to "modernize" Uganda. Criminalizing indigenous practices was one way to accomplish this goal. For instance, the 1957 Witchcraft Act made any action illegal that was in direct contradiction to Western norms, religion, and medicine. Local practices, such as consulting ancestral spirits to restore health, were denoted as witchcraft and, thus, illegal.

Efforts to incorporate indigenous medicine into the Ugandan health sector have occurred in recent decades. For example, the 1987 Health and Policy Review

Commission recommended that: the primary healthcare system should include indigenous medicine; a national association for healers should exist; the MoH should actively train healers (for instance, bone setters and TBAs); biomedical and indigenous practitioners should refer patients to each other; the Natural Chemotherapeutics Research Laboratory should regulate herbal medicines; and indigenous practitioners should be recruited to identify herbal remedies (Yahaya, Aryeija, and Bitwari 2004:3).

In addition, four Ugandan NGOs attempt to advocate for and regulate ethnomedicine and the training of indigenous practitioners. First, the Association for the Promotion of Traditional Medicine (PROMETRA-Uganda) aims to strengthen collaboration between indigenous medicine and biomedicine (<http://www.prometra.org/Uganda/uganda.html>). PROMETRA-Uganda offers training and education of healers, the establishment of cultural centers to aid the exchange of ideas among varying types of medical practitioners, and the environmental conservation of indigenous medicinal plants. Second, the Traditional and Modern Health Practitioners Together against AIDS and other diseases (THETA) attempts to bring together indigenous and biomedical practitioners. THETA trains healers in community counseling (with an emphasis on sexually transmitted diseases) and maintains a resource center and library in Kampala (<http://www.thetaug.org>). Third, the International Institute of Alternative and Complementary Medicine (IIACM), headquartered in Kampala, is a clearinghouse for 10,000 Ugandan medicinal plants which includes the formulation, processing,

and packaging of herbal medicines. Finally, Herbalists Association MAKOHA (MAKO) works to identify indigenous herbal medicines and to train practitioners and users in applications of these documented herbal medicines (Weisheit 2003:3). Because these organizations are constrained in their outreach potential (e.g., they are located in Kampala) and because a handful of governmental policies restricting indigenous medicine still exists, there is little hope that Uganda will be ranked as an integrative system that fully incorporates and legalizes indigenous medicine.

NGOs and Ethnomedicine in Karamoja

Uganda's tolerant policies have led to limited national efforts to document, reproduce, and promote indigenous medicine – most often in the form of marketable herbal remedies or in the biomedical training of local practitioners. But very few agencies have taken note of Karimojong healing strategies. Thus Karimojong practices and therapeutic strategies are judged to be culturally and ideologically harmful and “primitive,” rather than valuable contributions to the biomedical establishment. Opportunities have been missed and will continue to be missed unless a more serious effort is undertaken to accept, protect, and promote Karimojong indigenous medicine.

Nonetheless, two Moroto-based NGOs have missions to document and market Karimojong medicine. The first group, the Karamoja Christian Ethnoveterinary Program (KACHEP) (see Gradé, Tabuti, and Van Damme 2009), is an offshoot of the Christian Veterinary Mission (CVM). KACHEP started in 1998, but was not registered as an NGO until 2004. As part of KACHEP, CVM

veterinarians worked with Bokora and Pian Karimojong to identify an indigenous pharmacopeia used for livestock. KACHEP's research documented Karimojong indigenous knowledge regarding the identification, collection, preparation, and administration of herbal remedies to treat livestock illnesses.

The Traditional Livestock Healers Association, part of KACHEP, is composed of 60 healers who attend meetings and receive training to improve the efficacy of indigenous healing methods. The Traditional Livestock Healers Association maintains that it offers an arena in which indigenous medicine – for both livestock and humans – can be shared publicly among healers themselves, and also disseminates this information to other pastoralists and NGOs working in similar communities. One such effort is the chronicling of Karimojong indigenous remedies (listed in 2009). While this program certainly offers a forum for Karimojong healers to discuss their work and trade valuable information, its relevance is limited to healers associated with CVM. Furthermore, this program is rooted in a Western ideology (Christianity). This may act as a barrier to those Karimojong not wanting Christian ministry or to those who participate in practices deemed sinful by Christianity, such as the communication with Karimojong spirits. I found that Christian healers are the exception rather than the norm in Karamoja.

A second organization, the Karamoja Traditional Healers and Health Systems Project (KATHES), operates in three of Moroto District's subcounties. Although one of these three, Rupa subcounty, is also the site of the present study, no healers I interviewed spoke of KATHES. This may be attributed to the fact that KATHES was

not an official NGO until August 2008, although it was registered as a community-based organization in 2006. KATHES' aim is to create "intercultural medicine" built on the collaboration of "traditional healers and the official health system" (<http://moroto.go.ug>). I spoke directly with two KATHES representatives – a doctor and a nurse who both worked at Moroto Hospital. They explained that KATHES hoped to market local herbs as valid healing remedies within the hospitals and to create a Karimojong herbal remedy manual developed from interviews with healers. This book, *Intercultural Medicine in Karamoja*, is not yet complete but will promote and distribute Karimojong healing methods to the biomedical establishment, fulfilling one goal of the intercultural approach of KATHES.

While this approach could bring Karimojong indigenous medicine the validity it deserves, it remains to be seen if this organization will compensate healers or protect them from biopiracy. On the surface, the book appears to provide very little benefit to the Karimojong healers, but a very large benefit to the biomedical establishment: marketable herbs that could be commercialized for profit. Both KACHEP and KATHES must proceed with caution and adequately address how they plan to capitalize on alternative healing but also safeguard Karimojong intellectual property rights. WHO (2002) condemns the unauthorized, misappropriation of indigenous knowledge, particularly in regard to herbal remedies and healing methods, a factor yet to be addressed by the marketing of Karimojong medicinal technologies.

While both KACHEP and KATHES have missions to support local health practitioners, their organizations have not made themselves widely known to the larger Moroto Karimojong community. This may be especially true for individuals living far from the main trading centers or town where these NGOs are headquartered. The KATHES representatives, in fact, stated during our conversation that the incorporation of practicing Karimojong healers from the rural villages was one of their greatest challenges. Interviews with healers in the present study confirm this fear. Only one Karimojong healer I interviewed reported any association with an official healers' association or organization. This healer described his participation in international events where healers displayed their herbs or used their divination sandals (MP1M 7/5/07).²⁷ No other healers were members, nor had they participated in either of the two Moroto-based programs outlined above.

Home Remedies and Mothers as Healthcare Providers

Karimojong mothers are under acknowledged for their roles as healthcare providers. Not only do mothers determine what healing avenue will be followed (e.g., when to use biomedicine and when to use indigenous treatments), they typically administer several doses of medicine before seeking assistance from health practitioners—both biomedical and indigenous. Mothers' role as primary care givers is common among Nilotic pastoralists. As part of a longitudinal analysis of health dynamics among Turkana pastoralists, researchers (Shell-Duncan, Shelley,

²⁷ The month prior to our interview he attended a competition in Kenya and two months prior he had traveled to Kampala for an exhibition.

and Leslie 1999, Shelley 1985) found that the maintenance of health and well-being is more in the domain of Turkana mothers than that of healers:

In addition to protective roles, mothers are also the primary persons involved in diagnosing and treating common ailments. Most sicknesses are considered god-sent [natural], and are treated on a routine basis at the homestead. Women have vast knowledge of therapeutic plants, and they prepare medicine openly in the social context of daily life (Shell-Duncan, Shelley, and Leslie 1999:213).

Karimojong mothers, like the Turkana, have a broad understanding of the prevention and treatment of childhood sicknesses. They use home remedies that include medical plants that mothers gather, prepare, and administer themselves; different types of clays or ochre which mothers smear on children for both illness prevention and treatment; and pharmaceuticals mothers buy from drugshops, borrowed from friends, or had from previous treatments. Home remedies are an amalgam of indigenous and biomedical methods.

Preventive Measures: Amulets and Clays

Karimojong mothers employ a series of protective methods to keep children healthy (Figure 7.1): children wear protective amulets; mothers keep infants vulnerable to misfortune completely covered or away from strangers who may cast evil eye; they decorate infants' carrying pouches with amulets to ward off threats; and they smear their children with a variety of local clays during seasonal or ritual events. Following the slaughter of an animal for curative, religious, or celebratory events, Karimojong tie strips of the animal's hide on afflicted or young children. These strips can also be placed along common paths to ward off enemies or disease.



Figure 7.1 Protective Clay and Amulet (on neck)

Amulets protect people from enemies, sickness, or evil; prevent raids or drought; and may cause an abundance of good fortune (Novelli 1999:67). One particularly desired amulet is the *aoke* (*ngaokei*, plural). According to informants, *aoke* is an atypical piece of a plant and difficult to locate. *Aoke* can be found on a variety of plants and has different magical qualities. For instance, a certain *aoke* can increase one's goat herd if it is buried within the goat's pen, whereas a second type of *aoke* is used by warriors to make their enemies fall asleep after they blow a portion of the *aoke* into the wind (KK167 5/3/07). In general, *aoke* prevent misfortune and thereby maintain well-being. Karimojong place some *aoke* inside piece of cloth that are then tied to a necklace. Most informants were hesitant to talk about their amulets, especially those tied in cloth and worn by children.

Karimojong mothers also smeared clays on their children without the advice of healers. Mothers smeared clays for preventative measures or during ritual events rather than as curative treatments. *Emunyen* (clay or ochre; *ngimunyenin*, plural) have numerous purposes: "medical ones, as remedies for certain diseases; social

ones, as ornaments of the body, daubed with them for dances; and magic ones as preventions against evils; but, it seems, they are also used in religious circumstances” (Novelli 1999:99). During rituals, Karimojong smear clays to appease Akuj and ask for blessing for the ritual. Some clays also have protective qualities; thus, warriors often smear themselves with clay before going on a raid, whereas mothers may smear their children to protect them from evil eye before they set out for a long journey. Finally, clays have a curative quality. Karimojong smear different types and colors of clay as a treatment in and of itself. As medical treatments, however, mothers smeared clays on their ill children only after a healer divined which color and type was necessary for the specific set of symptoms and circumstances.

Ngikito: Karimojong Medicinal Plants

The NgaKarimojong word for medicine is *ekito* (*ngikito*, plural), which is also the term for a tree (Farina 1983, Novelli 1999), and underscores their reliance on plants as indigenous medicines. All parts of the plants—root, stems, bark, leaves, and fruit—are utilized as medicine and prepared in a similar manner: a portion of the plant is harvested, lightly crushed, and infused in water. The herbal tea then may be drunk, mixed in a soup or porridge to be eaten, given as an enema, or used for bathing. Karimojong also grind dried medical plants into a powder which may then be either consumed or rubbed directly into wounds. Gradé and colleagues (2009:275) reported similar findings among 209 medical plants used to treat livestock ailments:

The most commonly used parts are bark (26.8%), underground organs (roots and tubers) (24.3), leaves (19.2) and fruit (13.7). Some preparations call for only one part whereas others allow for more....Most listed remedies used a single plant ingredient (87.2%), typically soaked in water; only 12.8% of recipes were preparations that used more than one plant.

Among the Karimojong lay persons and healers alike have an understanding of herbal remedies. Mothers collect, prepare, and administer medicinal plants prior to seeking additional assistance from either healers and/or the biomedical community. Mothers also administer medical plant concurrently with other healing methods. When describing how she treated her child's sickness, one mother reported that she administered seven herbs before using biomedicine.

The baby started with a fever like she had malaria so I treated her with medicinal plants first. I gave her *eusugu* [knob wood],²⁸ *ekitoi ngolo aliban* [the plant that is green], *ngolo ka emoru* [the plant which comes from the mountain], and *ekitoi ngolo kiryonon* [the plant that is black]. Then the baby healed and stayed well for some time. Later she had diarrhea so I gave her *emutorin* [resin tree].²⁹ That comes from the tree we are now sitting under. The diarrhea reduced for a bit and she stayed without diarrhea for some time. Then suddenly the diarrhea increased one day. It was yellow stool and it refused to go away. I continued treating her with *ekamuriae* [couch grass],³⁰ *emutorin*, and *emus* [a thorn³¹]. I mixed *ekamuriae* and *emus* and gave the herbs as a drink and an enema.

Normally it would only take three to four days for the ngikito to work. But I gave the herbs to her for five days and the yellow diarrhea refused to stop. I decided to take the baby to the clinic. The nurses there said the baby was also malnourished and gave her three bottles of drugs and five small red tablets that I had to mix with water to give her twice a day.

²⁸ *Zanthoxylum chalybeum* (Gradé, Tabuti, and Van Damme 2009:292)

²⁹ *Ozoroa insignis* (Gradé, Tabuti, and Van Damme 2009:289)

³⁰ *Carissa spinarum* (Gradé, Tabuti, and Van Damme 2009:283)

³¹ *Euphorbia uhligiana* (Shelley 1985:185)

For us here we use both ngikito and clinics. I find them both to be the same. But, I like herbs so much because even if the sickness falls at night I can go collect them myself (MP45 4/25/07).

Mothers' reliance on medicinal plants was linked to financial as well as convenience factors. Herbal remedies, when collected without the advice of a healer, are free, whereas consultations with healers or biomedical practitioners and purchasing pharmaceuticals are not. The mother quoted above reported it was not until her child's symptoms became severe that she decided to seek help from the HC level III clinic, which charged 1,000 shillings for medical treatment. The cost, along with the long distance traveled (it was at least a two-hour walk one way to the clinic) were the main reasons she persisted with the herbal remedies before seeking biomedical treatment sooner. A second mother stated, "I use herbs when I don't have any money. If there is fever, I dig up *edongodongomurae* [the pinching grass].³² For fever, this plant heals fast" (KK8 5/31/07).

Mothers reported that they collected and prepared herbal remedies only when necessary. Herbal remedies are fairly abundant and cheap—it is only the labor and associated dangers (such as venturing too far into the bush where the raiders may be hiding) that deter Karimojong from collecting these herbal medicines. Some mothers said they also kept a small amount of herbs in their huts for emergency medicine, but most mothers reported that their stocks were empty at the time of the interviews. A mother explained,

³² *Edongodongomurae* comes from two NgaKarimojong words: *edongodong* "pinching" and *emurae* "the creeping grass" (Verona Fathers 1986).

When a child is sick, I first gather plants. I get whatever herbs I need according to the type of sickness. I know that a certain type of sickness requires a certain kind of herb. For fever there are herbs along the riverbed and some others are located beyond the river. I learned this from other mothers who would say that this plant worked well for this certain illness. I also spoke to ngamurok who showed me how to prepare the ngikito (AD78 4/9/07).

All mothers in this sample, however, stated that their knowledge of medicinal plants was limited and that they sought assistance from healers for more complicated concoctions or if symptoms worsened. For instance, mothers may administer medicinal plants in conjunction with biomedicine (if they believe the pharmaceuticals are proving ineffective) or at the instruction of a healer. One woman explained, "The diarrhea didn't stop with the pills so I resorted back to the herb. Then the diarrhea stopped" (MP53 4/15/07). Another mother stated that she only used medicinal plants after the advice of a healer, "I don't have any herbs here at home. I go to an amuron who will dig the ngikito for me. For this I have to pay the healer" (AP98 5/7/07).

Mothers sought care from a healer for the specialist's wider knowledge of the medicinal remedies and for "their ability in curing the psychological ailments which normally go with the physical ones" (Novelli 1999:124). Although mothers are knowledgeable on the preparation and efficacy of some medicinal plants for the treatment of common child sicknesses, mothers admitted that their understanding of Karimojong medicine does not compare to that of healers. Healers' knowledge of medicinal plants was great. Four healers were able to name 20 or more indigenous plants, their medicinal values, and preparation methods. One healer (KK3M) named

62 herbal remedies, their preparation and administration protocols, and the specific ailments for which each was therapeutic.³³

Healers' Work

The Nuer, Turkana, and Karimojong all refer to their Nilotic healers with the same general term: *emuron* (singular) / *ngimurok* (plural) for males; and *amuron* / *ngamurok* for females (Dyson-Hudson 1966, Evans-Pritchard 1956, Knighton 2005, Shell-Duncan, Shelley, and Leslie 1999, Shelley 1985). The word *emuron* or *amuron* is a general term encompassing all acts associated with divination and may also refer to an indigenous medical practitioner. However, healers fall along a continuum ranging from medical specialists to generalists who incorporate Karimojong cosmology into their healing practices.

The Karimojong maintain a broadly bound definition of what it means to be “one who treats.” Karimojong refer to any healer as an *emuron* or *amuron* but grades or rankings of healing specialists – each with distinct names – exist (Dyson-Hudson 1966, Novelli 1999). Dyson-Hudson (1966:120) observed that “ritual specialists are scattered throughout Karimojong society, and though they have different powers and fields of activity, and vary greatly in their influence, they are

³³ I predict this number would be far greater had I both the foresight and opportunity to ask herbalists for an exhaustive list of their medicinal plant knowledge. I originally asked mothers and healers alike to name herbal remedies that they were the most familiar with or used on a regular basis. I also obtained information regarding medicinal plants during illness and healing narratives. After sitting down with one herbalist (MP6) who named 34 herbal remedies during our first interview, I realized this was a new area worth investigating. However, collection of a detailed list of herbal remedies was time consuming, and as such, I was not able to do so during all interviews with healers. Collecting an exhaustive list of herbal remedies is a priority for my continued research on Karimojong medicine.

all known by a single term (*emuron*).” To compile and understand the Karimojong folk classification system, I asked informants to categorize the different types of healers (Table 7.1).

Informants provided either descriptive titles, such as “the healer who removes false teeth” (*amuron ngina elemi ngikyel*) or shortened titles that refer to the healing act alone (“removes false teeth” – *akilem ngikyel*). Informants identified 23 types of Karimojong healers. These categories covered a wide range of work and healing techniques, talents, healing instruments, and tools. One healer explained,

Akuj gives us different gifts and ngimurok are of different types. Some have knowledge to look at sandals to see answers and cures for people. The sandals can show that a certain color animal [for sacrifice] or clay is needed. Akuj gives the power to heal through the animal sacrifice or the clay after it’s smeared. Or the sandals will show which herb is needed to cure the sickness (KK3M).

Healers’ work is focused principally on divination and may include the following: slaughtering animals for sacrifice; haruspication; interpretation of thrown sandals for divination; interpretation of signs to cure sickness; preparing and distributing herbal medicine; and removing harmful charms or administering protective spells (Novelli 1999). Healers combine divination with medical expertise to alleviate symptoms or to cure sicknesses. According to Novelli (1999:120-121), “while the former [divination] tries to cure the psychological side of the illness, the latter cure the physical aspect of it [sickness] through local medicines.”

Table 7.1 Classification of Karimojong Healers

<i>Healing Generalists</i>	
A. SOOTHSAYERS / DIVINERS	
1.	Haruspices: <i>ngimurok ngulu iryoman ngmoliteny</i> ; male healers who can read animal entrails to foretell events
2.	Dreamers: <i>ngimurok ngulu erujan / ngimurok ngulu eperiaka / ngikerujak</i> ; male healers who have prophetic dreamers
3.	Sandal diviners: <i>ngimurok ngulu akilamilam ngaamuk / ngimurok ngulu ngaamuk</i> ; male (and occasionally female) healers who cast or repeatedly throw (akilamilam) sandals and interpret their positions to foretell events
4.	Spirit-gourd diviners: <i>ngamurok ngulu ngililae / ngamurok ngulu ngakasikou / ngamurok ngulu akiyek ngililae</i> ; female healers who communicate or shake (akiyek) the spirits (ngililae) or old men (ngakasikou) who use a divination gourd
5.	Cowrie-shell and coin diviners: <i>ngamurok ngulu akilamilam angisigera ka ngisilinga</i> ; female healers who throw cast cowrie-shells (angisigera) and coins (ngisilinga) to foretell events
B. TREATMENT GENERALISTS	
1.	Herbalists: <i>ngimurok</i> (or <i>ngamurok</i>) <i>ngulu etamasete ngitunga ngikito</i> ; male or female healers who give people medical plants
2.	Slaughter animal sacrifices: <i>ngi/ngamurok ngulu akiyar ngjul</i> ; male or female healers who slaughter animals for healing sacrifices (Note: this is an independent category from the haruspices)
3.	Smear clays: <i>ngi/ngamurok ngulu ngimunyaenin</i> ; male or female healers who prescribe and smear local clays or ochre
4.	Incisions or cuttings: <i>ngi/ngamurok ngulu ngidungon</i> ; male or female healers who make incisions or cuttings either for bleeding or to rub herbal remedies in
5.	Cupping horn: <i>ngi/ngamurok ngulu akinak</i> ; male or female healers who use a cupping horn to suck out afflicted parts
6.	Drain abscesses: <i>ngi/ngamurok ngulu akiped</i> ; male or female healers who drain by piercing (akiped) abscesses (resulting from a variety of sicknesses)

Healing Specialists

C. SICKNESS SPECIALISTS

1. Evil eye: *ngamurok akilem ngakonyen ka akapilan / ngamurok ngulu abukut*; female healers who extract (akilem) evil eye (ngakonyen ka akapilan) using a processed sisal ball (abukut)
2. False teeth: *ngamurok ngulu akilem ngitiang* (or *ngikyel*); female healers who extract the unerupted canine teeth (ngikyel), the “false teeth,” or wild animals (ngitiang)
3. Genital growths: *ngamurok ngulu akilem ekidima*; female healers who extract genital growths (ekidima) from women (Note: if these growths are not removed the affected women’s children can develop a fatal sickness)
4. Wind spirits: *ngi/ngamurok ngulu akilem ekuwam*; male or female healers who extract the wind spirits (ekuwam) from the afflicted
5. Pneumonia or chest problems: *ngamurok ngulu akilem lokore*; female healers who treat a specific chest illness – pneumonia (lokore)
6. Gripe: *ngi/ngamurok ngulu akilem ciriai*; male or female healers who treat gripe (ciriai)
7. Open fontanelles: *ngamurok ngulu lokes*; female healers who help close babies’ open fontanelles

D. COUNTER ACTS OF WITHCRAFT

1. Bodily charms: *ngi/ngamurok ngulu akilem*; male healers who remove charms placed on or in the body of the afflicted
2. Buried evil things: *ngi/ngamurok ngulu ekusete / ngikakut*; male or female healers who can locate and remove evil things buried (akikut = to dig hole)

E. WOMEN’S REPRODUCTION

1. Massage barren women: *ngamurok ngulu akiret*; female healers who administer massage (akiret) to help women get pregnant
2. Remove retained placenta: *ngamurok ngulu akiret ka alemun atiang*; female healers administer massage to remove placenta (atiang = wild animal)

F. MISCELLANEOUS SPECIALITIES

1. Rainmaker
 2. Initiate other healers: *ngi/ngamurok ngulu akitamuronor*; male or female healers who initiate other healers
-

Particular Karimojong healers have the ability to communicate with Akuj or the spirits in an effort to determine a curative treatment, action, or resolution plan.

Informants identified five types of soothsayers (A1-A5 in Table 7.1): four use

physical objects – sandals, gourds, animal entrails, or cowrie shell/coins – as divination instruments, whereas the fifth interpret dreams. Although any Karimojong can perform these same divination acts, healers apply their expertise for the medical benefit of others (Novelli 1999).

Six healing categories referred to generalized therapies (B1-B6 in Table 7.1) that could be used to treat a variety of sicknesses. These included herbalists who gather, prepare, and administer medicinal plants; healers who slaughter animals as a sacrifice; those who smear clays for medicinal or protective purposes; those who incise the skin as part of the healing treatment; those who remove illnesses through a cupping horn; and those who drain abscesses. These therapeutic skills are applied to a variety of illnesses rather than used for one type of sickness. For example, healers who make incisions may do so both to promote bleeding (as a measure to relieve pain in a swollen area or to purify the body) or to rub herbs into the cuttings as a treatment for a variety of ailments.

Karimojong informants also identified classes of specialists. These healers specialize in either a particular sicknesses or therapy. Six categories (C1-C7 in Table 7.1) referred to medical experts capable of treating specific illnesses: evil eye (*ngakonyen ka akapilan*), false teeth (*ngitiang* or *ngikyel*),³⁴ female genital growths (*ekidima*), pneumonia (*lokorei*), unclosed fontanelles (*loke*), and stomach sickness or gripe (*ciriai*). Two classes of specialists (D1-D2) cure witchcraft by removing charms actually placed on humans or buried in the homestead. Two additional (E1-E2)

³⁴ Ngitiang is the NgaKarimojong word for animal, whereas ngikyel translates as teeth. Karimojong refer to the unerupted canines (i.e., the false teeth) as “animals,” indicating that they are not a normal, healthy part of the mouth.

classes focus on women's reproductive health, assisting barren women or removing retained placentas. The final two classes of healers (F1-F2) included rainmakers and those who initiate other healers.

Healers' Multiple Roles

The Karimojong healer taxonomy was developed from both mothers and healers during interviews. Mothers reported more categories than those self-identified by healers (see Table 7.2 for healers' self-identification of therapies and specializations). For instance, none of these healers reported that he or she could counteract witchcraft, were rainmakers, or initiated healers. This could be because healers in this sample did not believe these acts were unique enough to merit separate healing categories (i.e., these duties were incorporated as part of the generalized healing therapies). The simplest explanation is that the healers did not perform these duties. In addition, healers may have been reluctant to speak about their role in anything associated with controversial or formally illegal acts such as witchcraft. Mothers, however, felt strongly enough to include these categories because they believed that negative charms can greatly impact child health.

Table 7.2 Informants' Self-Identification of Healing Classes

ID #	Healer Type
<i>Male Healers</i>	
AP1M	A2; A3
AP2M	A2; A3; B1; B3
KK3M	A3; B1; B2; B3
MP1M	A3; B1
LT2M	A3; B1; B2
MT1M	A2; A3; B1
MT3M	A1; A2; A3; B2; B3
<i>Female Healers</i>	
AP15	A4; B1; B2; B3; C1; E1
AP41	B1; B4; B5; B6
AP43	A4; B1; B2; C1
AP50	A4; B1; B3; C1; E1; E2
AP142	A4; B1; B4; C1; C2
AP149	A4; A5; B1; B2; C1
KK99	A4; B1; C1
KK128	A3; A4; B1; B3; C1; C2
KK139	A4; B1; B2; C1
KK141	E2
KK178	A4; B1; B3; B4; C1; E1
MTC	A3; B1; E1; E2
AD214	A4; B1; B2; C1
MP6	B1; B2
MP36	B1; E1
MP68	B1; B2
MP73	B1
AD155	C2; C3
LT1	A4; B1; B4; C1
MT2	A4; B1; B2; B3; C1
MT4	A3; B1

One woman noted, “Healers have several roles. Like the one who throws sandal, he may also slaughter sacrifices. Or, the healer who removes evil eye usually has a divination gourd as well” (MP40 4/13/07). Twenty-six of the healers reported they had multiple talents and therefore self-identified with two or more categories. The two healers who reported a single healing specialization should be considered outliers and were not representative. The first woman (MP73) claimed that she was only an herbalist now but she had performed three additional therapies: soothsayer with a divination gourd, removal of evil eye, and animal sacrifices. This elder woman recently became baptized as a Christian and gave up all Karimojong healing practices demonized by her Christian priest. Even though she only self-identified as having one specialization, this woman had an apprentice (MP68) to whom she was teaching all her indigenous therapies including those which she had herself renounced.

The second woman (KK141) was a TBA who specialized in removing retained placentas (*akiret ka alemun atiang*). However, this TBA received biomedical training 10 years prior, which she attributed to her husband’s political pull in her community rather than to her innate capabilities in aiding pregnant women. I included this TBA in the healer category because she categorized herself as such, but she represents the more technically trained healer. Furthermore, this woman works closely with her sister, Naciyo (see below), a well-known healer.

Ngimurok: Male Healers

The typology of Karimojong healers is loosely tied to gender. Both male and female healers are soothsayers, herbalists, and have the knowledge and capabilities to treat male, female, and childhood illnesses that fall within the healers' and specialists' categories. However, male healers participate more often in nonhealth-related consultations, such as divining when herders should go on a raid or when the rains will come. For instance, at *akiriket* (the sacred meeting place where elders determine community-wide activities) ngimurok slaughter one or more animals (cow, goat, or sheep), examine the animals' entrails and advise the elders on a plan of action. *Akiriket* occurs prior to large-scale events that will affect an entire village, such as the start of livestock migration at the beginning of the dry season. At *akiriket*, it is the healers' job to divine the best course of action (e.g., when to begin migration and in which direction the herd should travel). Thus, at *akiriket*, as in the case of smaller village-wide gatherings such as the rain ritual discussed in Chapter 6, the role of the ngimurok is not directly related to a medical event, but rather pertains to community well-being.

Ngimurok are also more likely to be: haruspices, dreamers, and sandal diviners. Haruspication, foretelling events by "reading" animal entrails, is common among East African pastoralists (Abbink 1993). Haruspices examine the entrails of slaughtered animals—most often cow, goat, or sheep—and then interpret the entrails in regard to a query. *Akuj* and/or the spirits can communicate messages through the size, shape, coloration, and any abnormalities found in the entrails. Among the

healers I interviewed, only one man (MT3M) classified himself as a *haruspex*; others in the sample most likely had this skill too, but focused instead on their other healing qualities. Few healers may self-identify as intestine-readers because divination is not an activity solely assigned to indigenous healers. Elders are commonly the *haruspices* during public rituals, such as a cattle-blessing ritual, but *ngimurok* are often called to perform this duty in the private realm. These healers perform *haruspex* in conjunction with their other healing work. Abbink's (1993) research among East African *haruspices* indicated that during readings performed for personal purposes (in contrast to public rituals) or on behalf of a sick individual, a local healer may actually read the entrails, but it is the audience that derives interpretations from the reading.

Although acknowledged experts take the lead in interpreting the entrails, they cannot claim any firm authority on the basis of their expertise. Instead, they let the inferential process run its course. Entrail-reading is thus a running commentary on pertinent problems in the community, urging people to take these problems seriously, to be prepared for them and, if necessary, to take redressive action. It sensitizes people to problems of communal life, urging them to work towards harmony or towards renewing the social contract (in some instances to be taken quite literally) between local groups, affines and 'lineage' (ibid:722).

Four men in this sample self-identified as dreamers. As with reading entrails, having prophetic dreams is not confined to healers alone. Any Karimojong may at some point experience divinatory dreams; however, a special class of healers – the dreamers – not only have the dreams but can offer advice, on the basis of those prophetic visions, concerning health and well-being. Furthermore, ordinary

Karimojong who have visionary dreams usually seek the help of an emuron to both interpret the dream and determine the course of action. One healer-dreamer reported, "I only have dreams when Akuj wants to talk to me. I can be sleeping at night or just resting under a tree. I dream a lot of people plowing, enemies, rain, and when animals or people are sick with particular diseases. I can even dream what color clay or sacrifice is needed for treatment" (AP1M 3/17/07). Another healer (MT3M) explained that he first realized he was an emuron as a young man after predictions he made based on his dreams came true. He next mastered haruspex and then went on to become a soothsayer using divination sandals. Currently, he also slaughters animals for sacrifice, is an herbalist, and smears clays on patients. This man is an uninitiated healer who taught himself all of his skills rather than experiencing amuronot.

All seven ngimurok I interviewed reported they were sandal diviners. Sandal diviners are one of the most popular classes of Karimojong healers. Patients and clients go to sandal diviners for medical treatment for both human and livestock illnesses as well as for general advice regarding overall community health, well-being, and social relations. To determine a course of action, sandal diviners throw a pair of sandals (usually made of hide) into the air and then interpret the position in which they landed. Sandal diviners will repeat this task several times in a row, until the plan of action has been made clear. According to Novelli (1999:118), the talent of sandal diviners reflects a combination of geomancy (the interpretation of lines on the

ground) and cleromancy (casting lots) and is usually used to resolve minor problems of everyday life.

Lotiang, a Renowned Emuron

Karimojong healers' reputations depend on their success and relative influence both within and beyond their communities. Lotiang, a middle-aged man from village AP, earned his reputation for healing early. Lotiang (AP2M) was initiated as a healer when he was a baby. The spirits imbued him with the wisdom of divination, the ability to smear clay, and the knowledge of numerous herbal remedies. The spirits also gave him his divination sandals, which he demonstrated during our interview:

Lotiang holds both his sandals in one hand with the soles placed together. He taps them on the ground several times, brings them near his mouth, spits on them, and then rubs the sandals to his chest and forehead. With a flick of his wrist he throws the sandals to the ground and quickly starts the process again. Lotiang does this three times without speaking. On his fourth throw the sandals land near a woman (AP98) who has come to visit. She says that the sandals jumped to her. She picks up the sandals, rubs them against her forehead and chest, and then hands them back to Lotiang. The sandals land on top of one another after the fifth throw. Lotiang explains that this means we [Akol and I] will leave the hut safely today and will have no problems during our drive home. After two more throws, Lotiang quits, says his sandals have finished talking, and tells me to proceed with the interview.

MBS: Why did you stop throwing the sandals?

Lotiang: I was delaying because there will be a problem in [Village KK]. There will be a raid there tomorrow or in two days time. Fortunately, there is nothing bad for you or for our village here.

WOMEN (AP98): Are there any steps that Village KK can take to prevent the raid?

Lotiang: There is no clay for them to smear that can rescue them. But, a sheep the color of a spleen should be sacrificed.

MBS: How do you know this?

Lotiang: The sandals showed me.

MBS: How do you read the sandals? Is each throw completely unique in its meaning?

Lotiang: A particular position can mean a certain emunyen.

MBS: Does that position always indicate the same color of clay even for different circumstances or cases?

(Lotiang throws his sandals again and they fall perpendicular to one another, sole sides down.)

Lotiang: This here means “skinning animals.” This shows that someone’s animals are about to die.

MBS: How many times do you throw the sandals for your patients?

Lotiang: There is no certain number of throws required. It is when the sandals come to the stop position that I know Akuj is done talking and has shown me what should be done (AP2M 6/6/07).

A testament to Lotiang’s reputation as a reliable healer came later that same evening when I saw an informant (KK178) from Village KK. After telling the woman about Lotiang’s prediction, this woman immediately left to warn the elders of her village. Several days later she returned to visit and related that there was a raid the morning after Lotiang’s prediction. The village elders refused to slaughter the required sheep, not because they did not believe Lotiang, but because the young men in her community were still relatively well-armed and were willing to fight off any raiders, (which they did successfully).

Lotiang's skill in both curative and preventative remedies for humans and livestock is well known beyond his own village. Patients travel from as far away as Kotido District (north of Moroto) for his assistance. Lotiang reported that barren Jie women, who live in Kotido, often come to him for help. In a typical week he advises up to 30 patients or clients. The day I interviewed him, he had already met with four patients: a barren woman; a man who lost cattle during a raid; a herdsman preparing for a journey; and another herdsman concerned about the health of his animals. Lotiang prescribed herbal remedies for the barren woman, used his divination sandals to determine the appropriate clays to recover the lost cattle, used his sandals to divine when the herdsman should go on his journey; and divined with his sandals the specific animal for sacrifice (as needed to protect the herds' health). His work that morning exemplified how Karimojong healers are both soothsayers and healthcare providers.

This is in contrast to the analysis of Turkana sandal diviners who have been depicted as being soothsayers who do not provide medical assistance or advise outside the spiritual realm (Shell-Duncan, Shelley, and Leslie 1999, Shelley 1985). Turkana diviners only determine the underlying cause of misfortune – whether a sickness is the result of natural circumstances and can be treated medically or if it is of human-origin (i.e., some form of ill intent or witchcraft) and must be cured using spiritual means. These researchers (*ibid*) contend that Turkana ngimurok can cure spiritual illnesses using divination, but do not provide further medical treatment. In contrast, I found that Karimojong soothsayers have the knowledge and capability to

divine the underlying cause of misfortune as well as prescribe or treat the malady whether it is natural or spiritual in nature.

Karimojong healers, like any other kind of medical provider (including biomedical doctors and nurses) diagnose, prescribe, and administer remedies; thus, they are indeed healthcare providers whose work is not limited to the spiritual realm alone. They use divination to determine the source of illness, curative approaches, and protective measures. Some healers may simply prescribe the treatment course, such as a specific herb, clay, or ritual to perform, leaving the actual course of action (i.e., gathering the medicine, preparing it, and administering it) to the patient's family. Other male healers, like Lotiang, both prescribe and administer local medicine. One emuron (KK3M) stated that when a patient seeks his help he first uses his sandals to determine the type of sickness and the appropriate treatment:

I can give herbs or if the sandals tell me a certain color of clay or sacrifice is needed, I tell the patient to get that. The patient's family must bring the designated animal back here to me so I can make sure that it is the right color. I am the one who will slaughter it, but I don't read the intestines. For that I call the old emuron" (KK3M 6/9/07).

This man also demonstrated his medical knowledge—making him more than just a diviner—as he identified 61 Karimojong medicinal plants, including what specific sickness each one is used for and how he prepares and administers the herbs to his patients.

Ngamurok: Female Healers

A broad division existed among the female healers (*ngamurok*): those who were officially initiated were soothsayers, whereas the uninitiated female healers

were not.³⁵ Healing generalists and sickness specialists (see Table 7.1) appear to be more technically trained. It might be argued that these healing specialists should not be considered Karimojong ngamurok; however, I included them because in response to my question “What types of Karimojong healers are there?” informants listed them as such. Furthermore, the majority of healer informants identified themselves as *both* diviners and health generalists and/or sickness specialists. A more restrictive view of what it means to be a Karimojong healer might only include those individuals who work as soothsayers.

Female healers classified themselves into 13 types of healing categories whereas the male healers only self-identified with 6 classes. These 13 categories ran across the entire local healing spectrum and included soothsayers as well as healing specialists. Ngamurok and ngimurok overlapped in the following categories: herbalists, those who smear clay, those who slaughter animals for sacrifice, and sandal diviners (a characteristically male activity). One of the three female sandal diviners also had a divination gourd, which she used more often than the sandals to communicate with the spirits (KK128 6/11/07). No female healers reported being dreamers or haruspices.

Sickness Specialists

The female sickness specialists emphasized ailments that are particularly virulent in childhood and which only Karimojong medicines could manage. No healers identified themselves as specialists for categories C4-C7 in Table 7.1, which

³⁵ One healer (MP68) is excluded from the initiation analysis. This informant did not provide any demographic data nor information pertaining to how she became a healer.

suggests that while mothers believed these four sicknesses – spirit possession (ekuwam), pneumonia or chest problems, gripe, and open fontanelles – were illnesses that required care from Karimojong specialists, the healers themselves did not regard them as outstanding categories. Mothers listed these healer categories because their corresponding illnesses pose significant threats to child health. But because these illnesses are so common, healers simply regarded them as the pathologies most often requiring intervention (common childhood illnesses).

The remaining three specialist categories correspond to illnesses that can only be treated with indigenous medicine. First, *ngidim* (plural; *ekidima* singular) are genital growths on women; *ekidima* does not harm the carriers, but has potentially fatal outcomes to breastfeeding offspring if they are not removed. Only one uninitiated healer (AD155) identified as being “the one who removes *ekidima*.” According to Akol (personal communication), *ekidima*³⁶ is a fairly recent ailment (she first heard about *ekidima* in 1999) that affects women but not men and is beginning to spread throughout Karamoja. Only a trained healer can remove the wart-like genital growths, using a razor blade. No other medicine or treatment is applied; however, a mother may have to remove the *ekidima* with each pregnancy. A healer explained, “It is a new sickness from Akuj. Drugs can’t cure it, even local plants won’t work. The only treatment is to remove it with a razor” (AD155 4/22/07). *Ekidima* is difficult to diagnose. Mothers do not recognize they are carriers and afflicted children suffer from diarrhea and vomiting which mothers can

³⁶ I could not find a reliable translation for *ekidima*.

attribute to a different ailment first. Informants explained that the one distinguishing feature of ekidima is that the “child closes her eyes and continually cups her hands and feet, opening and closing them” (AD73 4/24/07). One mother who had ekidima removed three times stated, “It seems that Akuj is the one who keeps putting ekidima on mothers and if they refuse to have it removed, Akuj will kill their children. Now when I see that my baby is sick from ekidima, I buy a razor blade and go immediately to the amuron. I know it will come again as long as I’m reproductive” (AD78 4/9/07).

Second, Karimojong mothers were adamant that the only cure for “false teeth” was Canine Follicle Extraction (CFE) from a healer-specialist (*amuron ngina akilem ngikyel*). Four healers explained that they were specialists in CFE: two women who were also diviners, one specialist (who was also the specialist in ekidima); and one man (KK3M). False teeth are the unerupted canines which the Karimojong believe are responsible for a host of symptoms, including fever, mucoid diarrhea, vomiting, and skin rash, occurring within infancy (Gray, Akol, and Sundal 2009a). Healer-specialists extract the canine follicles with a sharpened piece of metal and a hook (Figure 7.2). One mother explained the process,

All of my children had their false teeth removed. These *ngitiang* [animals, i.e., false teeth] make a child sick all the time with fever, diarrhea, and sunken eyes. Some children get sick at three months old, for some at five months, and others even when they are crawling or sitting. False teeth can only be treated locally. An amuron gets a piece of metal, which is flattened and sharp at one end. She cuts on both sides of the gum and then uses the sharp side to hook the tooth out. After the false tooth is removed, no herbs are used. Ghee can be smeared in the wounds, but only once. As soon as the false teeth are extracted the diarrhea reduces (AP8 3/6/07).

CFE is one illness that has sparked great tension between the biomedical and local communities because healthcare workers have linked CFE to secondary infections as well as to increased mortality risks.



Figure 7.2 Tools Used During Canine Follicle Extraction

Third, removing evil things from the body, or more specifically evil eye, was the most often cited reason mothers sought assistance from Karimojong healers. Symptoms of evil eye include high fever accompanied by diarrhea and vomiting. Evil eye is a human-induced sickness in which one person—either through ill will or no fault of her own if she has inherited the ability—“throws” evil eye at others. Young children are particularly vulnerable, thus mothers take numerous protective measures. For example, prior to traveling a mother may sprinkle salt on her baby’s forehead and/or may tie an amulet (with salt or another protective “charm”) to the baby’s necklace. If one is struck with evil eye, it cannot be treated by biomedicine alone, although pharmaceuticals can be used in conjunction with indigenous

remedies. A mother explained, “When I see that my child is very sick with fever, diarrhea, and vomiting, or when I find someone in the homestead whom I don’t know, I rush the child to an amuron. The healer will remove the evil eye, but then I go straight to the health center for the final cure. It is drugs which will cure out all the underlining sicknesses” (KK161 5/26/07). Other women claimed that Karimojong healing was the only necessary cure and that once the healer removed the evil eye, the afflicted immediately improved.

Healers who treat evil eye use two important tools. First, they soften strips of sisal (from the succulent *Agave sisalana*) to make a malleable fiber that can be manipulated over the body of the afflicted. During extraction, the healer moistens the processed sisal (*abukut*) and then rubs it over the patient’s body. One healer demonstrated how she removed evil eye and explained that:

For me, I just use the sisal to remove those evil things from people’s body. I can just touch the body with my fingers, moving along the body. Where I feel a throbbing I know that’s where the evil eye is. It feels like a vein that is pumping and throbbing. Then I put the sisal on it to remove it. Once it is removed I throw it in the pot outside. If there is no evil eye, then I’ll say it is not there, but if it is there, I can remove it (AP142 3/20/07).

Another healer (Naciyo) described the process thus: “I pass the sisal over the sick person’s body. Where it gets stuck is where the evil eye is. When I rub the sisal over that spot, the sisal becomes very hot” (KK178 6/1/07). Once the healer removes the evil eye, she throws it away in a designated vessel (the second tool) which is located in her outer compound. Ngamurok warned that the evil things removed – which could take a variety of shapes including a large black eye, a frog, or objects not

normally found within one's body – could not be haphazardly thrown away, but must be relegated to a specific pot or vessel that is used for nothing else.

The Turkana also suffer from evil eye; however, it is not their ngamurok who treat the afflicted but elder women (*akatwan*, singular / *ngakatwan*, plural) known specifically for their skills in curing evil eye (Shell-Duncan, Shelley, and Leslie 1999:213-215, Shelley 1985:194-223). Turkana ngakatwan learn their trade through an apprenticeship, often from their mothers or other female relatives. Neither Karimojong mothers nor healers indicated that any lay person had this ability. Rather, Karimojong categorize any person who has the ability to remove evil eye as a healer. *Ngamurok akilem abukut* (healers who remove evil eye using sisal), however, are linked with a category of Karimojong soothsayers: *ngamurok ngulu ngililae* (healers of the spirits). In this sample all 10 healers who self-identified as ngamurok akilem abukut were also ngamurok ngulu ngililae. Thus, all healers who remove evil eye also have a divination gourd.

Ngamurok a Ngililae: Female Healers of the Spirits

The Karimojong healing gourd (*etwo*) houses ancestral spirits (*ngililae*) that ngamurok may communicate with during their divination sessions. Ngamurok a ngililae (or ngamurok ngulu ngililae) literally means “female healers of the spirits.” “It is clear that the ‘amuron a Ngililae’, in this case transfers her knowledge of the problems affecting the sick person and the remedies to be prescribed to the spirits, and on their authority she makes the diagnosis and prescribes the therapy, with greater efficacy on the psyche of her client” (Novelli 1999:127-128).

These healers use a divination gourd – a hollowed-out gourd with several pebbles inside – to communicate with their ancestral spirits. An amuron uses her divination gourd in the following manner: she shakes the gourd to make the pebbles inside make noise; the noise awakens the spirits, often of a man and woman related to the healer; the spirits communicate directly to the healer; and finally, the healer translates the spirits' wishes. Ngamurok a ngililae must always travel with their divination gourds and must pay special tribute to their ancestral spirits through libations of tobacco, beer, or food (Novelli 1999:66).

The gourd symbolizes a healer's rite of passage and is presented to the newly initiated during the *akitmuroiyar* ceremony (see Chapter 6). Uninitiated healers do not have divination gourds. One amuron a ngiliae, Naciyo, who experienced her liminal phase underwater with the spirits as a child, explained that although her gourd was a gift from the spirits, it was a fellow healer who prepared and presented the gourd to her during initiation. Naciyo's gourd houses those very same spirits who took her underwater. "The spirits in my gourd have the names of my clan. They are the same spirits that sometimes come and stand in my doorway to talk to me. When I started working [as a healer] I found the spirits had the names of my grandfather and grandmother" (KK178 6/1/07).

Communication with the spirits is not a prerequisite for healing, however. For instance, Naciyo described the symptoms and subsequent treatments for her last five patients. Four patients had evil eye for which Naciyo used her sisal to remove the evil parts and prescribed different herbs for each patient. A baby with measles

was her fifth patient for whom Naciyo prescribed a concoction of herbs in which the baby should be bathed in and fed with. In none of the cases had Naciyo consulted her gourd.

Two Healing Sessions with Cero

Cero (AP149) was the most popular healer that mothers in this sample consulted. Cero is not only an *amuron ngina ngililae*, she is also an herbalist, has the ability to remove evil eye, can slaughter animals for sacrifices, and uses cowrie shells and coins for divination. Cero is the step-mother-in-law of another informant (AP154) (see Appendix B for their respective household locations on the Map Village AP) and as such Cero frequently stopped by during my interviews with her step-daughter. I also interviewed Cero independently two times regarding her work as a healer and I attended two separate healing sessions in which she officiated — one in her home and the other at her patient's home near Matany trading center. Cero's healing tool is a gourd that had pebbles inside it. The pebbles assisted her to interpret the voices of her spirits when she rhythmically shook her gourd.

I had not intended to attend Cero's first healing session; however, one day when I dropped her off in Matany trading center she asked if I wanted to join her for "work." I quickly agreed and followed her, her daughter-in-law, and grandchild to a woman's compound at the edge of the trading center. A woman's child was sick and had called for Cero to diagnose the problem. Cero explained that the woman miscarried three times previously, but Cero's work with her enabled the woman to finally give birth. The session was as follows:

Cero puts a mat down on the ground, opens her black plastic bag, and removes a folded sheet which she lays directly on top of the mat. She has two smaller gourds inside the bag. When she takes them out, Cero says that someone has tampered with them. She explains these gourds represent her patient's ancestral spirits because she has worked with this woman for a very long time. The smallest gourd is the spirit of the patient's mother and the larger oblong one is her patient's father's spirit.

Cero sits on the ground and lays out a third gourd on the sheet. She then opens a tied piece of cloth and pours out 12 cowrie shells and a USH 200 coin. She picks up all the shells and the coin in her right hand, shakes them three times, and throws them on the blanket. She makes a clucking sound while she examines the shells. She says that when the gourds were tampered with is the time when the patient's child got sick.

Cero repeats the throwing process two more times. The mother and the ill child enter the hut and give Cero snuff. Cero snorts some of the snuff and then sprinkles the remaining amount on the gourd and shells. She then throws the shells and coin and "reads" their placement two more times without speaking. Next, Cero divides the shells and coin into two piles: on her right side she places seven shells and on her left the remaining five with the coin. Between the piles she begins shaking the largest gourd in a circular manner with her right hand.

After a few seconds the spirits talk—a muffled noise comes from deep within Cero's throat. Cero explains that there are two old men in her gourd. The spirits greet us in turn, one spirit at a time. Cero then tells me that it is time for me to go because the spirits need to talk to the patient's mother. (AP149 2/25/07)

Although I only stayed for the opening portion—when the spirits were "awakened" to greet us—I attended a full healing session with another patient several weeks later. This session occurred at Cero's compound in her day shelter. A young man and woman came to Cero complaining of infertility. The man and woman recently had married but had yet to conceive. Whereas I expected privacy to be ensured—as in the above example—the infertility healing session was performed

in Cero's day shelter while many people came and went. This could be attributed to the fact that the young couple brought sorghum beer with them for Cero, who readily shared with her neighbors, but in Karimojong society, infertility is a public, communal issue because large families are highly valued.

Cero brought her gourd into the shelter (the largest one she had used to invoke the spirits in the previous session) but kept it hidden under her shirt until she was inside. She began this session first with a drink of beer, followed by a second sip that she spat on the ground to appease the spirits. Cero next began throwing the 12 cowrie shells and coin. After three throws Cero said the couple has not conceived because: the man is a young singer who spends most of his time in Moroto Town, but his wife lives in the village; Cero recommended that the man make more visits home. Next, Cero snorted tobacco and sprinkled some on the gourd and cowrie shells. Speaking to the couple Cero said, "You must work hard to get pregnant or people will laugh and I will laugh. I will give you the very same herbs I gave my daughter-in-law to get pregnant." Over the course of the divination session Cero threw the cowrie shells 48 times. The session began in a light-hearted manner with Cero cracking jokes about the lack of intimacy between the couple—at several points when two cowrie shells would land on top of each other Cero would exclaim that that is how the couple should be at all times. However, by the 13th throw, Cero had divined that the young wife's mother was very sick. The woman confirmed that indeed her mother was sick, which was another reason she sought Cero's assistance. Throws 14 through 16 focused exclusively on the mother's condition: what type of

illness she had; what type of medicine was needed; and what actions the family must take.

Throws 17 through 25 revealed more information about the couple's infertility. Cero's consensus was that the husband did not visit his wife when she could conceive, but Cero had foreseen that they would get pregnant soon. On her 26th throw, Cero foretold the death of the woman's mother and on the next throw instructed the following:

There are two specific types of clay that will help. The first clay must be smeared. Then get the soil of a wasp's nest which you must mix with rabbit droppings and then smear on your mother's body. Next, a chicken with feathers that are a blue color must be slaughtered. On the day the chicken is killed, four long leaves of sisal are needed. I will prepare and use two of the sisal fibers to remove any evil eye that is affecting her. We will use the remaining two fibers to tie strings of the chicken skin to her body. Her body will then be cleared of sickness. If this is not done quickly, she may die. (AP149 3/12/07)

The next four throws reiterated the mother's treatment. The remaining throws (31-48) dealt with other family issues: the whereabouts of the woman's brother; the good health of the man's mother; and the prediction that the couple will soon get pregnant. At this point, Cero separated the shells into two piles (seven on her right and five on the left) and shook her gourd between them (Figure 7.3). The gourd's spirits gave a general greeting (one at a time) to each person sitting in the shelter. Cero then told everyone except for the couple, me, Akol, and Cero's daughter-in-law to leave.



Figure 7.3 Karimojong Healing Gourd

The spirits spoke and Cero translated:

The spirits are tired and want snuff [Cero snorts some and then sprinkles snuff on the gourd]. The spirits tell the man that children are the most important thing and that he must always know when his wife can get pregnant; it is his job to make her blood stop flowing. The spirits speak of a clay that the couple should smear on themselves and a specific herb the woman must consume so that she becomes ready to get pregnant (ibid).

The spirits did not speak of the ill mother, but instead focused solely on the couple's infertility. The spirits, however, were interrupted by several neighbors who again came to visit (and drink the beer). At that point, Cero put the gourd down and said that the spirits were insulted because they spent too much time upside down (i.e., they were on the ground at rest when others entered versus being used and held in the air).

Summary

The four most common types of healers were sandal diviners (*akilamilam ngaamuk / ngimurok ngulu ngaamuk*); healers who use sisal to remove evil eye (*akilem*

abukut / ngamurok a abukut); healers who consult a gourd with ancestral spirits (*ngamurok a ngililae*); and herbalists (*ngimurok ngulu akitamat ngikito*). It is through this communication with the divine that healers build both their following as well as their reputation.

Cero's healing sessions, as well as Lotiang's demonstration, exemplify Karimojong healing in action. Lotiang represents a classic emuron. He was a male soothsayer who used sandals as a divination medium to foretell events that have community-wide implications (such as the prediction of a raid). But, he also used his sandals to divine both the underlying cause as well as the remedy for human (and livestock) ailments. Meanwhile, Cero was the archetypal amuron: not only did she have a spirit-gourd, she practiced divination with cowrie shells, prescribed and prepared medicinal plants, and had a host of other healing responsibilities (including removing evil eye and slaughtering sacrifices). She threw her cowrie shells and coin in much the same manner Lotiang threw his sandals in that the cowrie shells were her medium for divination. During her healing sessions, Cero divined from the cowrie shells both the reason for the consultation (the child's sickness in the first and the couple's infertility in the second) and was able to discuss the state of well-being, or lack thereof, of other community members. From there she prescribed a therapeutic strategy which included actions as well as indigenous medicine.

Karimojong healers participate in acts of healing including divination and medical techniques or physical therapies. As healing specialists, *ngimurok*

administer a variety of therapeutic remedies, such as clay anointment, animal sacrifice, specific sickness treatment, and medicinal plants. Ngimurok also practice divination, using a variety of mediums, to advise patients or elders on resolutions or plans. Karimojong healers are quick to point out that their work is equivalent to that of any other medical practitioner: they determine the cause and treatment routine for ailments in an effort to promote or restore well-being.

Chapter 8 Normalizing Structural Violence

Structural violence is violence exerted systematically – that is indirectly – by everyone who belongs to a certain social order (Farmer 2004:307).

Poverty, racism, and oppression are shown to shape the contours of morbidity and death statistics through the unbalanced distribution of medical services and political and economic barriers to prevention and care (Kaufman 2004:249).

The unequal distribution of resources leading to poverty, ill health, discrimination, subjugation, and even death affects people over time and is akin to the slow withering away of bodies. These acts of everyday violence (Scheper-Hughes 1992) are as severe as other more immediate forms of violence (such as war) and can no longer be ignored, especially in anthropological analyses. An examination of structural violence enables critical anthropologists to “move easily from the local to the large-scale, tying together the ethnographically visible with the deeper structures that generate or perpetuate poverty and inequality and with the meanings these events and processes are given” (Farmer 2004:323).

Utilizing theoretical approaches of phenomenology and critical medical anthropology, this dissertation addressed the political and environmental processes that have shaped current health and healing trends among the Karimojong. These perspectives revealed how Karimojong perceive illness and well-being and enabled me to address the effect of violence, famine, and discrimination on Karimojong health and healing. Structural violence explains the ill health suffered by the Karimojong because an examination of it illuminates the relationship between the body politic and social inequalities that give rise to poor health outcomes. The day-

to-day realities of inequality and injustice that Karimojong endure have shaped their explanations and understandings of ill health and well-being and the efficacy of their therapeutic strategies. Poverty in Karamoja has been normalized due to the unequal distribution of resources throughout the colonial and postcolonial administrations in Uganda.

I was struck both by Karimojong mothers willingness to speak of extreme hardship and the manner in which they did so. Karimojong mothers repeatedly told stories about the difficult decisions they encountered to keep children healthy in the shadow of frequent child illnesses and deaths, near-continuous famine, violence (from cattle raids and harsh disarmament methods), and ongoing poverty.

Although mothers verbally expressed their families' struggles, they did so stoically with few outward expressions of sorrow. Often women related stories about a child's severe illness, or even death, while laughing about the obstacles they met along their failed healing paths. These women were not unloving mothers who did not feel pain or sorrow when they buried one, two, three, or more of their children, but women who were overwhelmed with their current hardships.

Normalcy

My son was admitted to Moroto Hospital for several weeks. The hospital discharged him, but after a few days he started vomiting. The women here told me that false teeth had disturbed the baby. We needed money for treatment so I tried to gather as much firewood as possible [to sell]. But by the late afternoon the baby's condition worsened. The amuron came to remove the false teeth, but my baby died before she arrived. My husband told our neighbors to keep watch on me so that I wouldn't hang myself. For me what could I do? Children here just die so I had to fight the temptation to follow the baby [in death] (MP45 4/12/07).

Karimojong have normalized ill health, poverty, lack of resources, and even child deaths as part of everyday life. This is a “cultural construction that arises when structural constraints of poverty, social inequality and sociopolitical marginality become internalized and taken for granted, forming an expectation of malnutrition, ill health, and limited access to health and sanitation services” (Timura 2007:179).

In her work among the marginalized in Salasaca, Ecuador, Timura (2007) found that mothers normalized child illnesses as a result of the structural constraints of poverty in which they lived. Salasaca mothers explained their children’s stunted growth and high morbidity as a result of their diets that lacked meat and local crops, which families were no longer producing themselves nor able to purchase at the markets due to their relatively high expense. Mothers expected that their children would repeatedly fall ill due to their extreme poverty, evidenced by their communities’ lack of infrastructure, public services, and medical resources. This normalization behavior was a coping mechanism mothers used to explain child illnesses and their poverty-stricken living conditions.

As discussed in Chapter 3, Scheper-Hughes’ (1985, 1992) examination of mother love and child death in Brazil addresses the political economy of emotions (i.e., how politics, economy, and culture shape emotions). She found that shantytown Brazilian mothers, like the mothers of Salasaca, were emotionally detached and had categorized child deaths as being a part of normal everyday life. The Karimojong have normalized child illnesses and death as well. At times some Karimojong mothers even practiced selective neglect of those children they deemed

too emotionally and monetarily costly to invest in. For example, one Karimojong woman in 2004 stated, “What is the value of this child? I should just throw him in the river. I am tired of this baby. Even if he dies I won't mind because he has disturbed me for so many months” (Sundal 2006). This mother’s distress, which at first blush appears callous, typified maternal responses in the present study to chronic child illnesses. Women simply had to prioritize the needs of the family over the needs of specific children; thus, women became less invested in children they deemed chronically ill or requiring too much of their constrained resources and time. These children will be the outcome of too many injustices endured by the Karimojong.

The Body Metaphor

One method to unpack the Karimojong’s normalizing behavior is to return to Scheper-Hughes and Lock’s (1987) mindful body. Within critical medical anthropology “the body becomes the vehicle, the site, the metaphor of expression, where all these issues come together and may be studied” (Janzen 2002:42). This conceptual framework “allows for an understanding of the body as individually and collectively experienced, as socially represented in various symbolic and metaphorical idioms, and as subject to regulation, discipline, and control by larger political and economic processes” (Scheper-Hughes 1992:135).

This dissertation analyzed Karimojong ethnomedicine using the three levels of the mindful body: (1) Karimojong therapeutic responses to ill health at the individual level; (2) their embodiment of suffering; and (3) the sociopolitical

conditions that have shaped their healing strategies. First, I examined the Karimojong experiences of illness and health. Sickness was represented among the Karimojong by the biological, psychological, and symbolic expressions of ill health at the level of individual bodies. Through illness narratives informants explained how their bodies and their children's bodies experienced illnesses and how medical treatments affected their bodies. It is at the individual level in which I amassed details about what types of Karimojong illnesses affect children (e.g., false teeth, *ekidima*, or evil eye), those of a spiritual origin (e.g., *ekuwam*), and those which indicate one's destiny as a healer (e.g., *amuronot*) and the corresponding therapeutic remedies. Because Karimojong mothers are their children's primary caretakers, they are often the first to diagnose and treat child illnesses. It is from their children's symptoms that mothers (and practitioners) determined the appropriate treatment plan. For many Karimojong illnesses these treatment plans included both biomedical and indigenous medicines. Therapeutic strategies, however, were constrained, shaped, and ultimately determined by resources often beyond mothers' control. Having Karimojong informants describe their bodily expression of illness was a beginning step to understand how they have experienced and normalized structural violence.

The next level of analysis of the mindful body focuses on the symbolic representation of nature, society, and culture within the social body (Scheper-Hughes and Lock 1987). The examination of the social body provided insight into how the Karimojong have embodied social inequalities, conflict, and injustices and

offered a model in which the cultural construction of normalcy became a coping mechanism mothers used to explain repeated child illnesses and death.

For instance, Karimojong informants reported specific causes (such as evil eye, measles, gripe, or ekuwam) when narrating therapy strategies, but their stories underscored the consequences of a bad diet (*epiane*) on child health. Mothers were keenly aware that their children's diets were nutritionally inadequate due to poor agricultural harvests and, more importantly, the lack of animal protein and fat usually obtained through milk, butterfat, and blood of their livestock. A common response to my first inquiry regarding child health, mothers stated *akoro bon* (hunger only). Mothers used this statement to illuminate the detrimental effects of their families' inadequate dietary intake and to indicate that their lack of food was considered a normal, repeated event. Mothers were resigned to the fact that many of their children would die before the next harvest. One mother explained:

Here in Karamoja if a woman is not hardworking, her children will die. Women work in casual labor, agriculture, and going to the river for wild greens; that's how we survive the hard times. It is also good that you pray to Akuj to stay healthy because if you as an adult get sick, then your children are at risk. When you are sick and just sitting about, your children will die of hunger (KK99 3/10/07).

Mothers reported that their children often went to bed hungry either because they were unsuccessful in selling goods to buy food or because mothers had slept in towns or trading centers overnight and were not home to prepare meals. In the past Karimojong women worked primarily within the home or nearby agricultural fields while caring for their children. Because livestock herds had diminished—to the

point that some women in the current study reported no milking animals at all – and agricultural crops continued to fail, Karimojong women were forced to seek casual labor to help provide food for their families.³⁷ Women’s reliance on casual labor removed them as their children’s primary caretakers. Although mothers would take breastfeeding children with them whenever feasible, some duties required mothers to leave young children at home while they worked. Women who sold goods in trading centers at times would not return home until the following morning because it became too late (and thus too unsafe) after they finally sold their goods or because they were too drunk to walk home. Drinking locally brewed sorghum beer throughout the day was not uncommon for men, women, and children in Karamoja. Mothers reported that they drank beer to ward off hunger and would provide beer to children for the same reasons; at times children were given only the dregs of beer as a meal. Thus, the suffering of the Karimojong – in this instance the struggle to provide food for their children while living in abject poverty – became embodied as normal childhood illnesses (or repeated illnesses).

A second example of the embodiment of suffering was revealed by the theme of infant disappearances during the Karimojong call to healing. In Chapter 7, I examined how healers and their families recognized they would become indigenous

³⁷ Mothers in this sample reported the following casual labor activities: collecting firewood or grass to sell; burning and selling charcoal; working in the army barracks; brewing beer; and traveling to neighboring districts to work as domestics or other manual labor positions. Mothers even sent young girls – often a teenager accompanied by younger siblings – to districts as far south as Kampala to work as domestics or to beg on the streets (Gackle, Lolem, and Kabanda ND, Russell, Kabanda, and Bett ND, Sundal Unpublished manuscript-b). Three Bokora mothers had young daughters in Kampala at the time of study.

practitioners. Several of the healers told stories that included moments when they were removed from their mothers' breasts and taken to the spiritual world. During their absence their mothers and other family members searched for them and sacrificed an animal to beg the spirits to release the missing infants. These actions are similar to those taken on behalf of ill children; mothers search for the proper therapeutic treatment, which may include an animal sacrifice or other communication (through the aid of a healer) with the spiritual world. When infants disappeared to the spiritual world mothers relied on practiced healing regimens. Losing infants (those who succumb to death) is not uncommon in Karamoja. What may in fact be more atypical is the return of ill or missing infants to a state of well-being. Thus, when infants returned to their mothers' breasts after spending time in the spiritual world, families rejoiced and marked the infants' procedure as being special and denoted them as future indigenous healers.

Although the Karimojong have normalized both their individual and social representations of poverty, inequality, and injustices in the form of repeated illnesses, hunger, and even death, another type of normalization has also occurred. It has become "normal" to blame Karimojong culture, or rather the stereotype of their culture for their suffering. Karamoja is the country's poorest region, characterized by lack of infrastructure, few socioeconomic opportunities, and ubiquitous ill health. In public discussions, low education levels, high prevalence of malnutrition, and escalating rates of morbidity and mortality are explained as the result of the Karimojong cultural heritage rather than a direct consequence of

structural violence. This public perception is reinforced by the media and political discourse. For example, then President Obote's comment in the 1960s – "We shall not wait for Karamoja to develop" – conveyed that Uganda would progress without the Karimojong and that investment in Karamoja was unwarranted and useless.

For decades the British and Ugandan administrations have demanded that Karamoja's pastoralists give up their lifeway in exchange for a "modern" sedentary subsistence. Blaming all the troubles on their culture masks the true source of suffering (Farmer 2003). For example, the explanation that Karimojong morbidity and mortality rates are so high because the Karimojong reject biomedicine and rely exclusively on Karimojong medicine is false. Karimojong pragmatically (at times desperately) use multiple therapeutic remedies even within the course of one illness bout. The misconception that Karimojong are a primitive people who rely on witchdoctors and reject modernity prevails, however. It is by examining the body politic (the third level of the mindful body) that "the decisions [which] are made about which bodies count" becomes visible (Timura 2007:185). Unfortunately, the Karimojong are not among the select few as exemplified by President Museveni's statement, reported in the August 6, 2009 *New Vision* news: "Corporate citizenship is more important than just citizenship. There are some Ugandans who are still running around like the Karimojong stealing cattle. Who is more useful to the country?" (Mugabe and Ssonko 2009).

The body politic (Scheper-Hughes and Lock 1987) is where inequities are constructed and reinforced. The political body has left Karamoja strapped with

inadequate infrastructure, education, healthcare, and economic resources. As evidenced by the political effort and policies put in place to segregate the Karimojong from the rest of Uganda, strip them of their cultural heritage, and deny them of their basic human rights, it is readily obvious that the Karimojong have suffered the devastating effects of structural violence. For far too long the Karimojong and their agropastoral neighbors have been dehumanized as primitive people who must abandon their cultural heritage to become civilized Ugandans. They are stigmatized as backward, violent, people who cling to their traditional values and are armed and willing to kill anyone inhibiting their pastoral lifestyle. This stereotype is often used to (inappropriately) justify mistreatment of the Karimojong, the lack of social services provided in Karamoja, and the ongoing disarmament in the region.

But is it really true that Karamoja's underdevelopment is a result of its people refusing modernity? Have the Karimojong opposed disarmament because they are inherently violent and care more about cattle than their children? An exploration of both how Karimojong cope as well as why they continue to struggle and suffer so greatly is long overdue. One cannot merely examine Karimojong health outcomes without examining the structures that were put in place that both created and maintained a population in such peril. Examination of the sociopolitical history of Karamoja clearly reveals the policies and structures put in place by both colonial and postcolonial regimes that have left this region in a state of continuing crisis. During colonialism Karamoja was segregated from the rest of Uganda, creating few

opportunities for Karimojong to migrate outside its borders. Colonial administrations sought to replace pastoralism, which was well suited to the ecological conditions of the region, with ranching and agricultural schemes. By restricting migration and grazing and enforcing cattle destocking, the Karimojong and neighboring pastoralists' struggle for survival intensified. Postcolonial regimes preserved colonial policies, resulting in the continued marginalization of pastoralists through the lack of infrastructure and social services, including adequate roads, schools, and biomedical facilities.

Holistic Healing

Although Karimojong informants normalized ill health and other outcomes of living in poverty, this does not mean that mothers did not actively provide healthcare within their means. Karimojong mothers desperately sought ways to alleviate ill health, utilizing both biomedical as well as indigenous medicinal strategies. Maternal responses indicated that Karimojong families do not solely use biomedical healthcare, nor are their healing decisions based on finances alone. The Karimojong, like many African populations, are medically pluralistic. Karimojong value biomedicine as a *complement* to but not a *replacement* for indigenous medicine. Biomedicine alone cannot satisfy all Karimojong medical needs. One reason for this is the legacy of colonialism, which discouraged and punished the use of indigenous medicine and has led to abuse of locals by biomedical staff who do not want to be posted in Karamoja. For instance, health facilities have difficulty staffing the most

rural units and employ mostly non-Karimojong (often Teso who are the bitter enemies of the Karimojong) for the professionally trained positions.

Discrimination was most overt in the abusive and corrupt behavior biomedical staff directed at Karimojong patients who used indigenous medicine. Karimojong women repeatedly told stories of nurses slapping patients or withholding treatment if mothers admitted using indigenous therapeutic remedies (Sundal 2008). Because they feared retribution, women used Karimojong medicine covertly or delayed seeking biomedical care until all signs of the local treatments disappeared. Fear of abuse by biomedical staff discouraged mothers from utilizing biomedicine to its fullest potential and placed children at greater risk. By proscribing indigenous methods, biomedical staff promote the stereotype that Karimojong medicine and thus the Karimojong are “backward.” The consequence of this stereotype is that indigenous medicine should be completely abandoned in exchange for Western-based methods, which, as this dissertation has shown, is neither applicable nor advisable to the Karimojong situation.

Furthermore, healers were proactive in their willingness to recommend other (e.g., biomedical) treatment strategies when their methods failed. I found that indigenous practitioners more adequately addressed Karimojong health needs because of their readiness to encourage alternative strategies and their less rigid classification of indigenous and biomedical approaches. Healers proved to be an invaluable medical resource for Karimojong families. Mothers actively sought assistance from indigenous healers to complement their home remedies (including

medical plants and minerals), to work in conjunction with biomedicine, and to provide the sole treatments for illnesses which only indigenous medicine could cure. Karimojong healing practitioners self-identified as a variety of classes of practitioners, ranging from initiated medico-religious healers to uninitiated medical specialists.

Conclusion

Although Novelli (1999) discusses Karimojong cosmology, and thus healers, this dissertation is the first study of Karimojong ethnomedicine in the context of maternal decision-making and the religious and medical roles of Karimojong healers. This dissertation addressed the following questions to address the impact of global processes of poverty and violence on Karimojong health. How do families, most specifically mothers, manage child illnesses in the face of ongoing violence, both external institutions (i.e., government disarmament campaigns) and internal institutions (cattle raids)? How have the roles of healers changed within Karimojong society? And finally, are biomedical facilities improving Karimojong child health and what policies and practices could be taken to better incorporate Karimojong healing within these health units?

Ethnographic data gained from one-on-one interviews with and observations of Karimojong mothers and healers revealed that the Karimojong utilize numerous healing techniques and do not rely on one unchanging medical system. My research incorporated a historical analysis of Uganda's healthcare sector, observational data of practiced healing strategies, Karimojong notions of health and illness, and an

examination of available biomedical programs in Moroto District. I examined maternal therapeutic decision-making in regard to healing management and health. I investigated the impact of biomedicine on Karimojong health and healing through an examination of the development of Uganda's biomedical care from its independence in 1962 to its current healthcare delivery system. This historical analysis traced the development of Western biomedicine, including the roles of faith-based organizations and the Ugandan government as healthcare providers. Based on ethnographic fieldwork consisting of interviews and observations among two primary categories of informants – mother and healers – I was able to better understand how Karimojong ethnomedicine is clearly medically pluralistic. A critical lens brought the focus up from Karimojong practices to illuminate the sociopolitical and economic factors that have created and continue to shape poor outcomes of child health among the Karimojong.

This dissertation expounded on the experiences of both Karimojong mothers and healers. Although these two groups are powerful and important healthcare providers, their contributions and healing work are largely unnoticed or relegated to the domain of religious and/or spiritual health. It is my aim that analyses provided here place the appropriate value on mothers and healers for their medical efforts. By better understanding indigenous beliefs and practices, healthcare interventions or programs could be better designed to fit the needs of the community rather than adhere to a prescribed notion of Western medicine. Merely examining child health outcomes – disease, growth, malnutrition – will not ease Karimojong suffering. I

suggest that to do so, one must examine why poor child health (and numerous child deaths) are considered to be a normal part of life in Karamoja.

This research developed from interviews of Karimojong living within two subcounties of Moroto District and is representative of rural Karimojong, a key group lacking among most studies of Karimojong health. A more inclusive study, one which contrasts the struggles and decision-making pathways of rural, semi-urban, and urban Karimojong families is needed to fully understand Karimojong ethnomedicine. In particular, a more comparative study would explore the relative impact of the various biomedical facilities and indigenous practitioners within the district. I hypothesize that informants within the current study rely more on indigenous medicine than Karimojong with greater proximity to the town and trading centers. Rural Karimojong, however, clearly utilized biomedicine and underwent great hardships to do so. I recommend that a more comprehensive biomedical healthcare program be established in Moroto District. Additional biomedical facilities are needed, ones in which the drug stocks are well supplied, the staff properly trained, and security (for both staff and patients) is maintained. Adding biomedical units is a starting point rather than an end goal. Merely building more facilities will not solve the healthcare crisis in Karamoja, especially if these units are duplicates of the current system in which indigenous practices and people are treated so poorly.

Furthermore, indigenous medicine must be recognized for its worth and incorporated in the healthcare sector. More research is needed regarding

Karimojong medicine and practitioners to develop realistic ways indigenous healers may coexist with biomedical practitioners as valued members of the medical community. Particular attention must be paid for the assurance of intellectual property rights in relation to indigenous knowledge so that the benefit of promoting Karimojong healing methods is not at the cost of the community.

Unless the conditions of poverty and inequality are eradicated and those in power who commit structural violence against the Karimojong are challenged, all these recommendations are useless. Researchers must strive to eliminate these injustices before any true improvements in Karamoja are to be had.

Appendix A: Informant Interview Questionnaires

Karimojong Mothers' Questionnaire

- I. Ego's Background
 - A. Personal Data
 - 1. Names
 - 2. Age / Birth Year
 - 3. Village Name
 - 4. Name of Homestead
 - a. When did you come to this homestead?
 - b. Why did you come to this homestead?
 - B. Marriage Details
 - 1. Are you married?
 - a. Were you married with cattle?
 - b. Have some cattle been transferred to your family (bridewealth payments made)?
 - c. Do you live with your husband? If not, where is your husband's homestead?
 - 2. What year did you marry?
 - 3. Do you have co-wives?
 - a. How many co-wives do you have? Please list.
 - b. Are you the first wife or the last wife?
 - c. Were any of your co-wives married with cattle?
 - 4. Is your husband at home or at the kraals (i.e. is he alive)?
 - a. What year did he die?
 - b. How did he die?
 - c. Was he old or young when he died?
 - 5. Have you remarried?
 - C. Children—ask each question for each child
 - 1. Do you have children?
 - 2. How many children?
 - 3. When was each child born? What are the children's birth years?
 - 4. Did you husband pay for the children?
 - 5. Are all your children living? (Of these children have any gone ahead of us?) How many?
 - a. What year did your child died?
 - b. How old was the child?
 - c. How did the child die? What caused him to go ahead of us?
 - d. Treatment methods prior?
 - 6. Other pregnancies and their outcomes?
 - 7. What do your children do during the day?
 - a. Do they go to school? Why or why not?
 - b. What type of work (responsibilities) do they do?

- II. Biomedicine
 - A. Health Care Facilities
 1. Which biomedical health care facility do you most often use? (Where do you go to get modern medicine?)
 - a. What type of facility is it? (Hospital, clinic, drug shop or somewhere)
 - b. What services does it offer? (What type of care do you get in that?)
 - c. How much do the services cost? (How much do you pay for..?)
 - d. Where is this facility located? (Where is this building?)
 - e. How far do you travel to get to this facility? (How far is it from here?)
 - f. What type of staff work there?
 - g. How does the staff interact with the patients?
 - h. Why do you use this one the most? (Why do you go to this one more than others?)
 2. What biomedical facilities are available to you? (Were else do you go other than___?) Get description for each facility she mentions.
 - a. Where are they located?
 - b. How much do they cost?
 - B. Pharmaceuticals
 1. Do you ever buy pharmaceuticals?
 2. Where do you buy the pharmaceuticals?
 3. How do you decide which pharmaceuticals to buy? (How will you think of the drugs you are going to buy?)
 - a. Does the seller tell you which ones to buy?
 - b. Do you decide on your own? (Do you alone decide what medicine to buy?)
 - C. Hospitals
 1. Do you ever go to any hospitals?
 - a. Which one(s)?
 - b. Have been to any located outside of Moroto District? If yes, which one?
 2. Have you ever gone to Matany?
 - a. How often?
 - b. What was your impression of the services and care provided?
 - c. What does the hospital charge for its services?
 3. Have you ever gone to Moroto Hospital?
 - a. How often?
 - b. What was your impression of the services and care provided?
 - c. What does the hospital charge for its services?
 - D. Please describe the details of your last visit to each of the health facilities.
 1. How did you make those treatment decisions?

2. Did you use any other form of healthcare including home remedies, drugshops, or local healing methods?
- III. Local Healing
- A. Local Healing Background
 1. What are the different kinds of Karimojong healers?
 2. How are the healers divided?
 3. What kinds of healers are men and what kinds are women?
 4. Are indigenous healers more often men or women?
 5. How do people become Karimojong healers?
 6. How are people made into healers?
 - B. Local Healing Tools
 1. I heard that Karimojong healers use clay/Is this true?
 - a. What are the kinds of ochre?
 - b. What is each color used for?
 2. Do healers make cuts to administer treatment?
 3. Do healers remove children's milk teeth?
 - a. How?
 - b. At how many months (age of child)?
 - C. Healers & Usage
 1. Have you ever gone to an indigenous healer?
 - a. How often do you go?
 - b. Do you go to many healers or just one?
 - c. Do you pay for treatment? If so, how?
 2. Why do you go to an indigenous healers?
 3. Does your homestead have a Karimojong healer?
 - a. How many?
 - b. What type of healers are they?
 - c. Are they well-known for their treatment methods?
 4. Do you ever go to healers outside your homestead?
 - a. How far do you travel?
 - b. Where are these healers living?
 - c. What type of healers are they?
 5. How do you decide (think) to go to a healer versus going to a biomedical facility?
 - a. Do you ever use both kinds of treatment methods for one illness bout?
 - b. Which are more effective—indigenous healers or biomedicine?
 6. Are there certain illnesses that only Karimojong healing can treat? If so, how and why?
 7. Are there certain illnesses that only biomedicine can treat? If so, how and why?
 - D. Herbal Remedies/Medicinal Plants
 1. Do you ever use herbal remedies?
 2. How do you know what type of herbs to use?

- a. Do you go to a healer for advice?
 - b. Do you collect the herbs yourself?
 - 3. How effective are herbal remedies?
 - 4. Can you list the herbs that you use the most?
 - a. How do you get these herbs (by yourself, on the advice of healers, purchase them at the trading center, etc.)?
 - b. What medicinal plants are readily available to you?
 - E. What other preventive or curative measures do you use to keep or restore your children's health?
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Healers' Questionnaire

- I. Ego's Background
 - A. Personal Data
 - 1. Names
 - 2. Age / Birth Year
 - 3. Village Name
 - 4. Name of Homestead
 - a. When did you come to this homestead?
 - b. Why did you come to this homestead?
 - B. Marriage Details
 - 1. Are you married?
 - a. Were you married with cattle?
 - b. Have some cattle been transferred to your family (bridewealth payments made)?
 - c. Do you live with your husband? If not, where is your husband's homestead?
 - 2. What year did you marry?
 - 3. Do you have co-wives?
 - a. How many co-wives do you have? Please list.
 - b. Are you the first wife or the last wife?
 - c. Were any of your co-wives married with cattle?
 - 4. Is your husband at home or at the kraals (i.e. is he alive)?
 - a. What year did he die?
 - b. How did he die?
 - c. Was he old or young when he died?
 - 5. Have you remarried?
 - C. Children—ask each question for each child
 - 1. Do you have children?
 - 2. How many children?
 - 3. When was each child born? What are the children's birth years?
 - 4. Did you husband pay for the children?

5. Are all your children living? (Of these children have any gone ahead of us?) How many?
 - a. What year did your child died?
 - b. How old was the child?
 - c. How did the child die? What caused him to go ahead of us?
 - d. Treatment methods prior?
6. Other pregnancies and their outcomes?
7. What do your children do during the day?
 - a. Do they go to school? Why or why not?
 - b. What type of work (responsibilities) do they do?

II. Local Healing

A. Local Healing Background

1. What are the different kinds of Karimojong healers?
2. How are the healers divided?
3. What kinds of healers are men and what kinds are women?
4. Are Karimojong healers more often men or women?
5. How do people become healers?
6. How are people made into healers?

B. Local Healing Tools

1. I heard that Karimojong healers use clay/Is this true?
 - a. What are the kinds of ochre?
 - b. What is each color used for?
2. Do healers make cuts to administer treatment?
3. Do healers remove children's milk teeth?
 - a. How?
 - b. At how many months (age of child)?

C. Herbal Remedies/Medicinal Plants

1. Do you ever use herbal remedies?
2. How do you know what type of herbs to use?
 - a. How did you learn this knowledge?
 - b. Do you collect the herbs yourself?
3. How effective are herbal remedies?
4. Please list each herbal remedy including part of plant, preparation method, and illnesses it is used to treat.

III. Healing Background

A. When did you become an indigenous healer?

1. How did you become a healer?
How did you start the healing process?
2. Are any of your family members also healers?
(Who have undergone rituals)
 - a. Who?
 - b. Is this person still alive?
 - c. What kinds of healer are/were they?
3. What kind of healer are you?

- a. Are you only one type of healer?
 - b. Are you a diviner?
 - c. What type of services do you provide?
 - 4. Are there any foods that you can't eat?
 - 5. Do you have any other restrictions or prohibitions?
 - B. Healing in Village (of the healer)
 - 1. How many Karimojong healers live in this village?
 - a. How are men and how many are women?
 - b. Where are they living?
 - 2. How many healers stay at your homestead?
 - a. What type of healers are they?
 - b. Do you do the same type of work as these individuals?
 - c. Do you ever work together with these healers?
 - 3. In one week, how many people (or cases) come to you for healing?
 - 4. Do people know you are a healer?
 - a. Do you treat Karimojong that do not stay at your place?
 - b. Do other Karimojong (like Pian or Bokora if Matheniko) come to you for treatment?
 - 5. What types of cases do you treat the most?
 - 6. Do you use ochre or clay?
 - 7. Do you do incisions (cuts for bleeding)?
 - 8. Do you remove children's teeth?
 - 9. Do you use sisal for extraction?
 - 10. What are you paid for healing people?
 - 11. Do you practice healing on yourself? On your children?
- IV. Local Healing & Biomedicine
- A. Which biomedical health facilities are nearby (here)?
 - 1. Do the clinics have a trained practitioner on staff?
 - 2. What is the difference between a drug shop and a clinic?
 - 3. Where is the nearest hospital?
 - B. Do any of your clients also use biomedical health facilities?
 - C. Do you ever treat patients while they are still undergoing treatment at the biomedical facility?
 - 1. Do you visit clients in the hospital and administer local treatment there?
 - 2. What do you believe the biomedical staff think about your work?
 - 2. Do you tell patients who come to you to use biomedicine rather than local healing treatment?
 - 3. Do you mix the medicine that the patients drink with that of biomedical facility in your healing work? (Do you incorporate biomedicine, such as pharmaceuticals, into your healing work?)
 - D. Do you ever use biomedicine for treatment for yourself?
 - E. How does Karimojong healing differ from biomedicine?
 - 1. How is Karimojong healing similar to biomedicine?

2. Which is more effective in healing?
- F. Does biomedicine and Karimojong healing treat the same sicknesses?
 1. Which sicknesses can only Karimojong healing treat?
 2. Which sicknesses can only biomedicine treat?

Appendix B: Homestead Maps for Selected Villages

Key for all homestead maps:

Outer Perimeter Fence Surrounding Cluster Homesteads



Fence surrounding homestead named after elder man



Cattle kraal



Goat/sheep kraal



Entrance



Woman's compound



Mother informant's compound



Female healer informant's compound



"Combined sample" informant's compound



Male healer's (wife's) compound

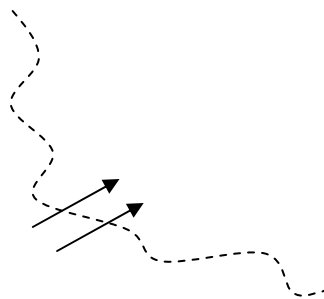
Indicates far distance between homesteads



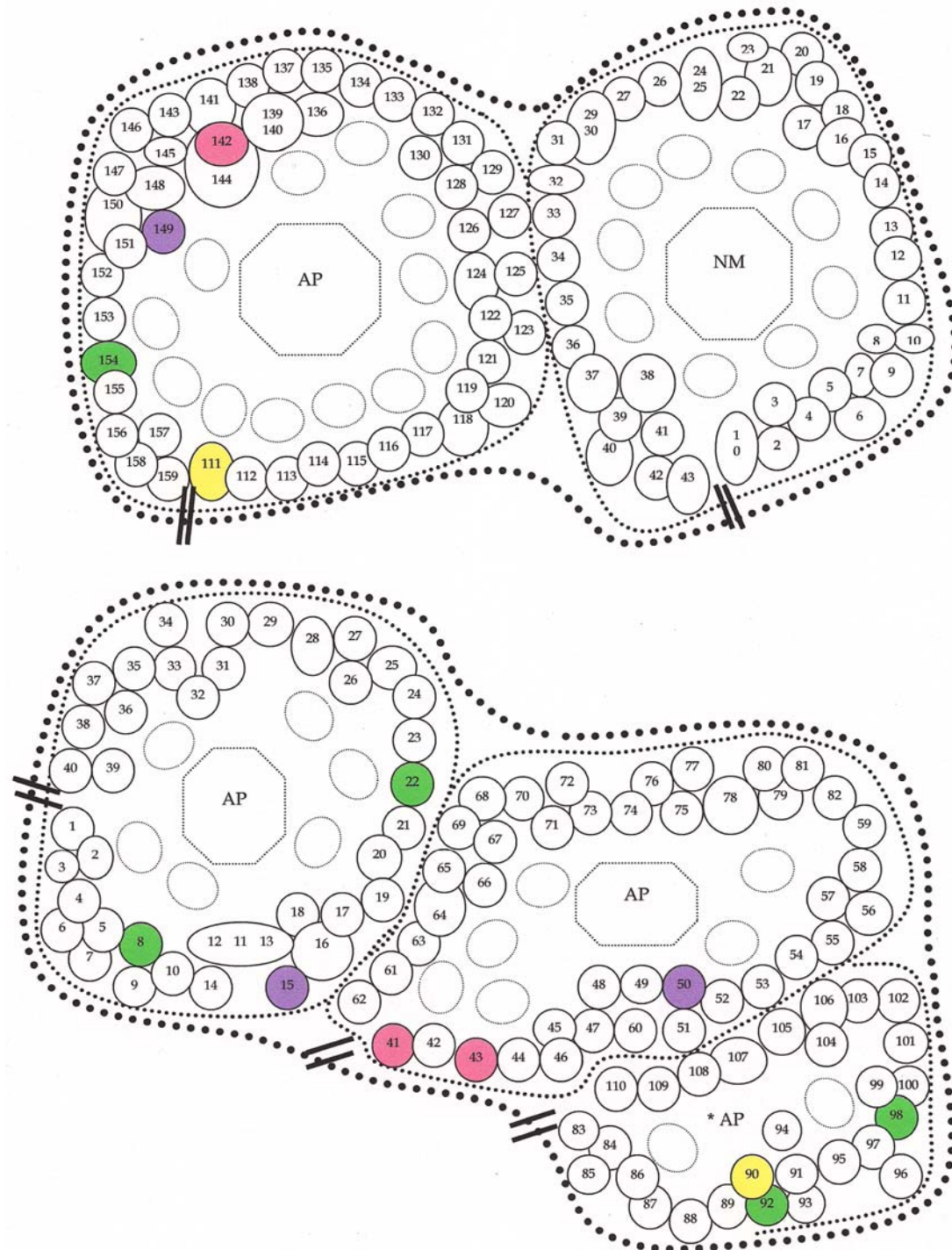
Stream



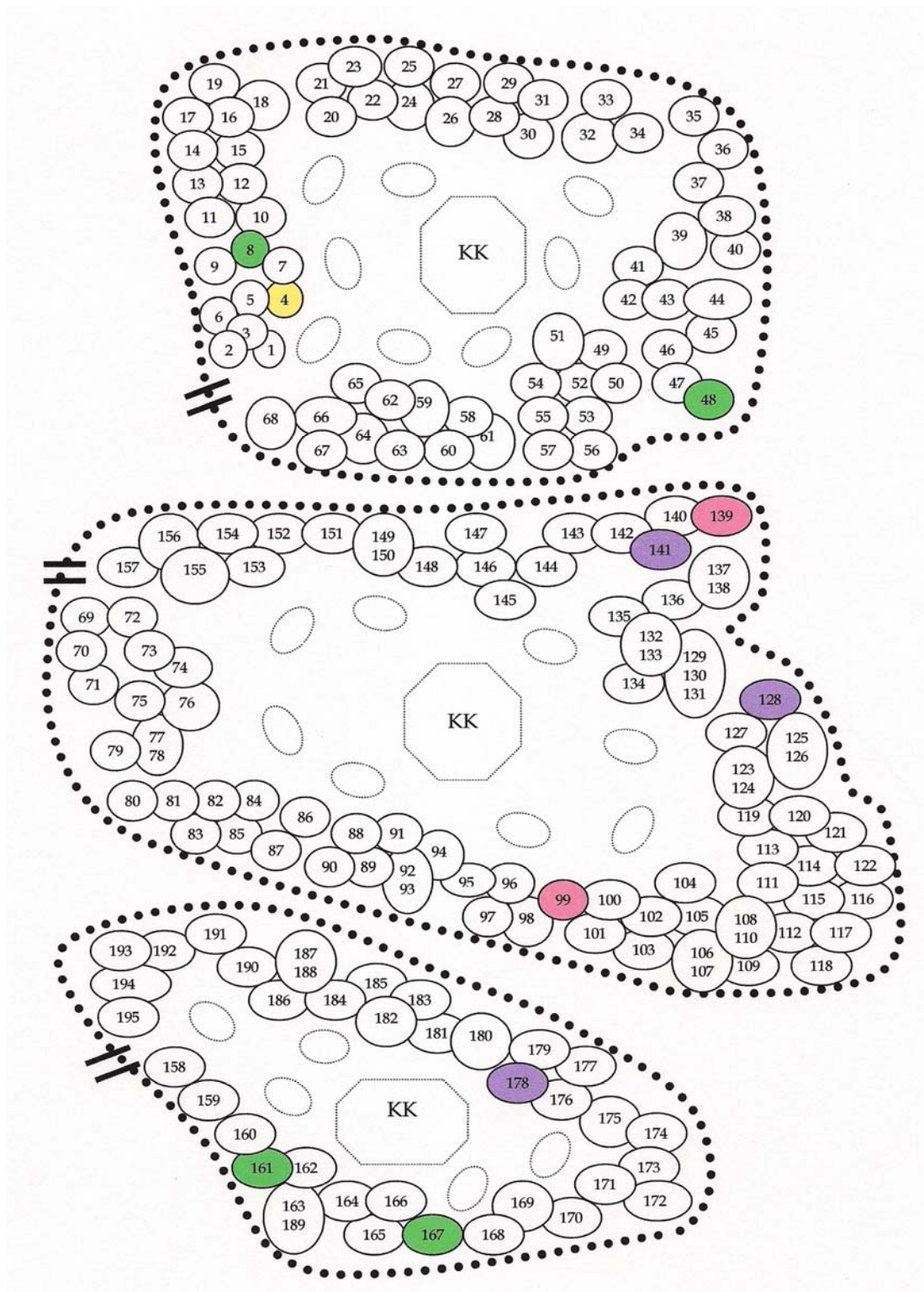
Mount Moroto



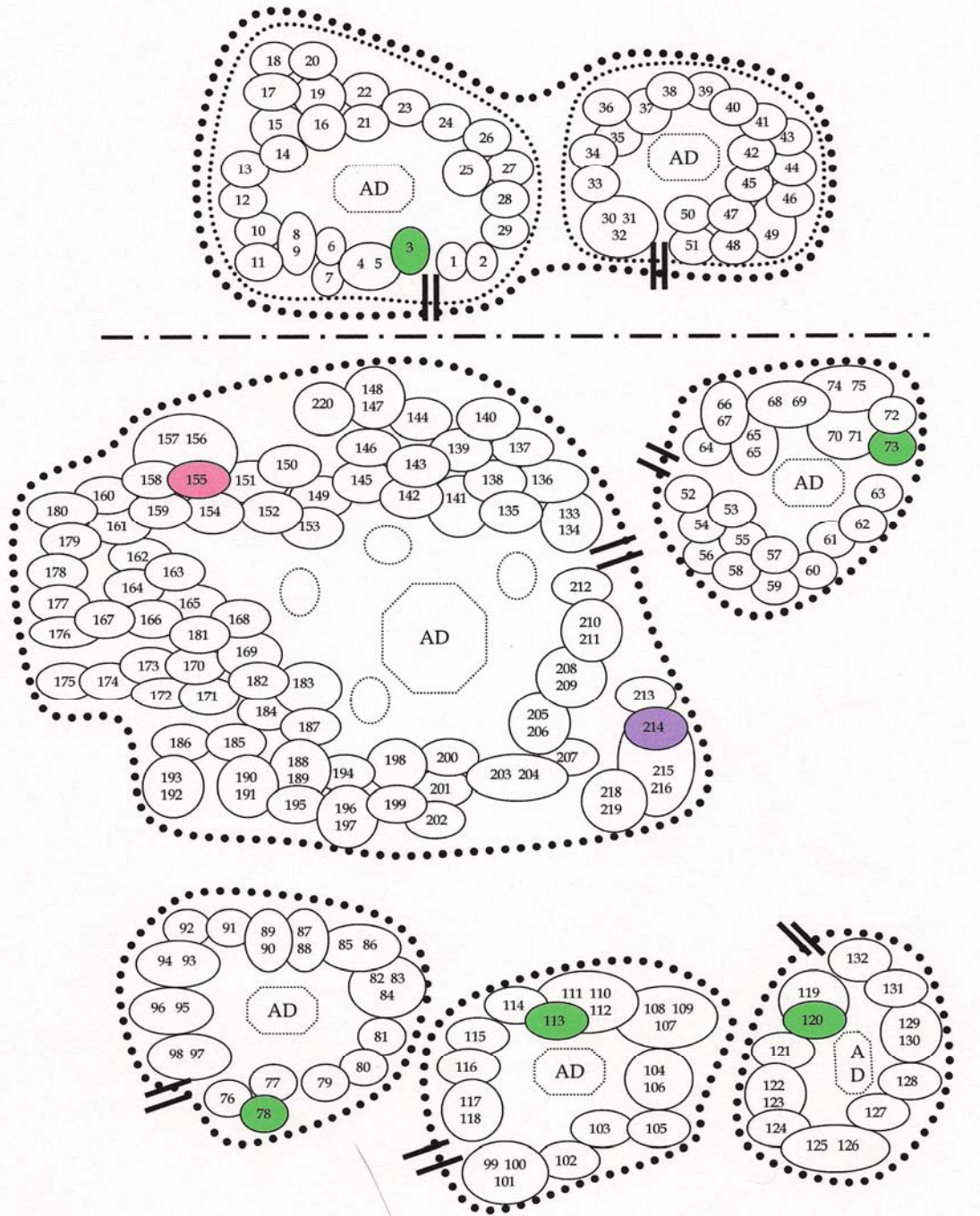
Homestead Map for Village AP



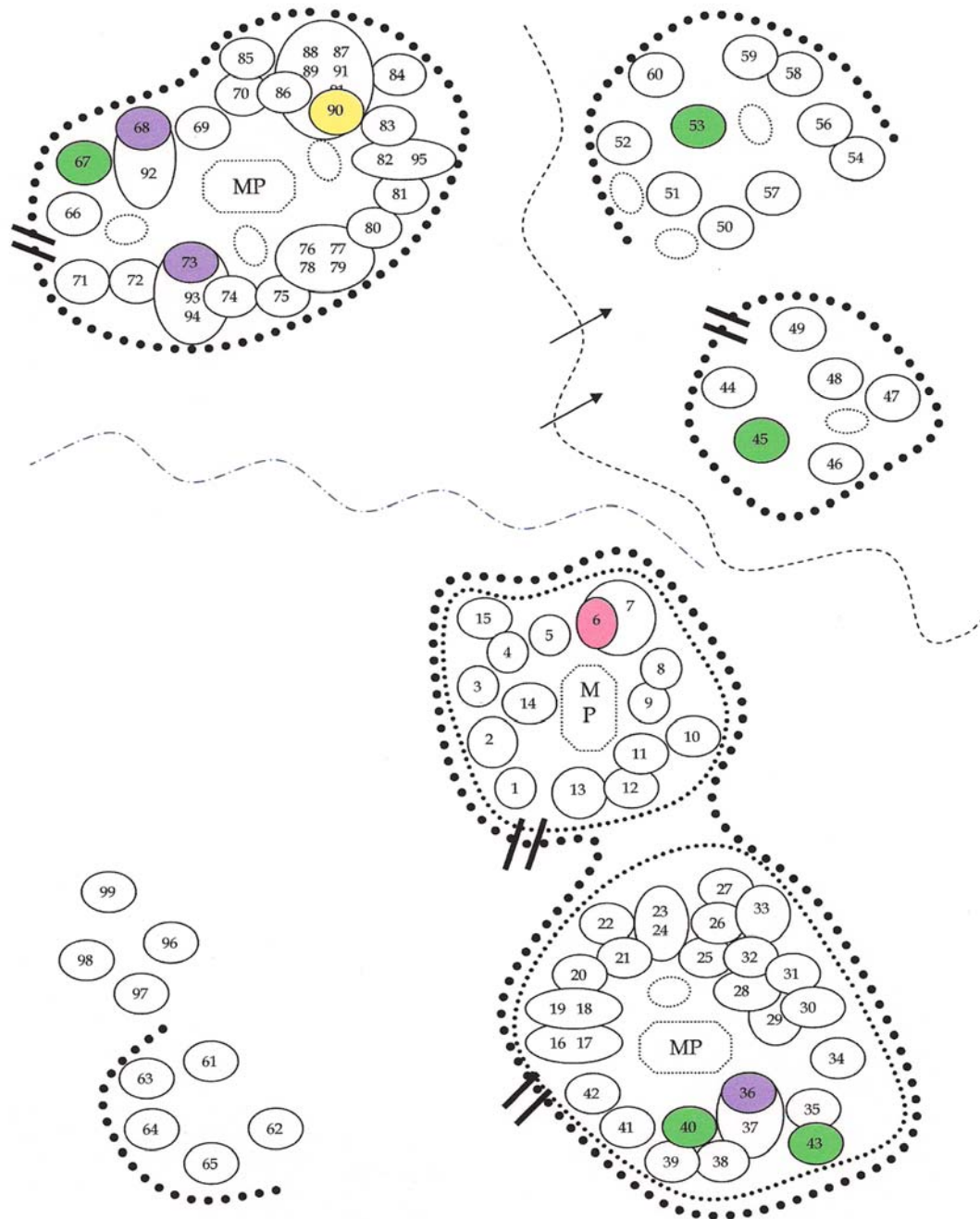
Homestead Map Village KK



Homestead Map Village AD



Homestead Map Village MP



Appendix C: Updated Local Event Calendar for Bokora and Matheniko, 1999-2006

1999	<p>Escalating violence between Matheniko and Bokora, and Tepeth and Matheniko.</p> <p>February. Matheniko raid kraals at Narengemoru, in Bokora.</p> <p>March. Museveni calls out UPDF troops to disarm Karimojong in surrounding districts (Kapcorwa, Katakwi, Soroti, Kitgum).</p> <p><i>Ekaru ngolo alo Moru Ariwon.</i></p> <p>No harvest.</p>	<p>January. Raid and massacre of Matheniko at kraals in Namalu, by Pokot and Tepeth.</p> <p>Matheniko kraals at Apule raided by joint Bokora/Jie party.</p> <p>Land surveyor, Okac, killed at Camp Swahili in Moroto, by Matheniko criminals.</p> <p>No harvest.</p>
2000-2002	Measles epidemic.	Same.
2000	<p><i>Ekaru abwanguniata Ngikumama ngitunga alo Komolo.</i></p> <p>Helicopter. Little harvest and drought.</p>	<p>Peace with the Jie.</p> <p>Little harvest and drought.</p>
2001	<p>Lokopo Dispensary built.</p> <p>Disarmament.</p>	Poor harvest. WFP distributing food.
2002	<p><i>Ekaru ngolo asurunio arianga ngitunga alo Kumana</i> 'The year soldiers dispersed and sent the Karimojong back from Teso.'</p> <p>Disarmament.</p>	
2003		Jie and Matheniko herded together in Nangololapolon.
2004	<i>Ekaru ngolo atwanitor elap</i> 'The year of the lunar eclipse (May 5, 2004).'	
2005		Famine. WFP distributed a lot of food.
2006		The famine continued.

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